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Alternative Treatment of Psychosis:
A Qualitative Study of Jungian Medication-Free Treatment at Diabasis

By

Michael Warren Cornwall

A Dissertation

Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

with a concentration in Counseling Psychology

California Institute of Integral Studies

Committee Chair
Minou Alexander, Ph.D.

San Francisco, CA
2002

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Minou Alexander, PhD, Chair

David Lukoff, PhD

Bruce Feingold, PhD

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ABSTRACT

Alternative Treatment of Psychosis:

A Qualitative Study of Jungian Medication-Free Residential Treatment at Diabasis

By

Michael Warren Cornwall

Diabasis, a medication-free, Jungian residential treatment center for acutely psychotic young adult clients, operated in the San Francisco mental health system in the 1970s. Using semi-structured interviews with participants in the program, review of archives, and examination of unpublished manuscripts, this study explicated the treatment approach and history of Diabasis. The literature review described the "medical model" that dominates the field and Perry's (1953, 1999) Jungian-oriented model, used at Diabasis, as well as several competing and complementary alternative perspectives on theory, diagnosis, and treatment. My research design, which intentionally avoided objectifying the process of psychosis or the individuals who went through this process at Diabasis, used Polkinghorne's (1989) multi-methodological "triangulation" approach for data gathering and phenomenological methods for data analysis. The results showed that the life and treatment philosophy of Diabasis founder John Perry, as well as the social milieu of the 1960s and 1970s, contributed necessary conditions for the existence of Diabasis. Its treatment approach hinged upon a particular "way" of being with psychotic residents—a unique Jungian style, evolved by Perry, that used a Taoist "active receptivity" to engage the archetypes of the collective unconscious as they expressed their powerful drama of affect and image on the stage of the Self. Participants' beliefs

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regarding the nature of psychosis tended to converge around three themes: (a) psychosis is not a unitary phenomenon; (b) for at least some people, it is both a purposive developmental process and an experience with strong transpersonal and archetypal elements; and (c) given the right kind of support, such people can come through the experience "healed." Participants were strongly critical of the medical model, which Diabasis sought to supplant, but also expressed retrospective criticisms of Diabasis itself. All felt that Diabasis continues to have a profound influence on their lives. The discussion explored some of the clinical, social, and theoretical implications of my study, as well as practical applications—including its relevance to the current growth of the consumer movement—and directions for further research. I hope my work will contribute to clinical understanding of psychosis and to developing alternatives to biopsychiatric treatment.

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ACKNOWLEDGMENTS

I first want to express my appreciation to all whose who participated in my study. The testimony of R.—the former Diabasis resident who shared her experience and was willing to revisit old memories of subjective suffering—gave my study its heart. All of my participants shared themselves with great openness. I am grateful for both their past work and their current desire to contribute to a rebirth of alternative treatment for psychosis.

Without the support and help of my beloved wife, Lisa Orlando, this study would never have happened. She is my comrade and partner in revolution. My amazing mother, Patricia Cornwall, gave me the wild spirit, and my precious daughter, Stephanie Cornwall, gave me the necessary motivation, to do this hard work. My uncle, Rich Cornwall, backed me all the way, even before, and especially since, Ron Cornwall—his brother and my beloved father—died.

My original committee members—Minou Alexander, David Lukoff, and the late John Perry—believed in and supported this project far beyond the call of duty. David was my "compass" throughout the many years it took to complete. Bruce Feingold agreed to be on my committee after Perry died and his suggestions challenged me to work towards greater clarity. I am very grateful to all of them.

John Perry was not only a committee member, but also a participant in my study, as well as, at various times, mentor, analyst, clinical supervisor, colleague, and friend. He helped me to overcome the legacies of original sin, Social Darwinism, and the Wasteland that almost got the best of me. Because he too was motivated by it, he helped me to

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clarify the real impetus behind this study: the desire to answer the prayer for rest and relief of suffering made by every person in a psychotic process.

I particularly want to thank all my past and present clients, including those at I-Ward, who taught me that complete recovery is more than possible, and those at the Antioch Children's Clinic, for helping me to believe in the future. I also want to thank the following people, who have contributed to this study and my life in various ways: Gary Smith and Tony Stopello, oldest of friends, who knew I would finish it someday; Debra Sell, "union maid" and best kind of friend—I could never repay what you have given me these last 10 years; David Shaw, my Rock of Gibraltar friend, I love you; Charmaine Hitchcox, great soul; John Allen, dearer than you know—"there but for fortune..."; Ray Newman and Stanley Mayerson, brothers-in-arms; Henry Clarke, Godfather of "realpolitick," mentor, and benefactor to so many of us; Sydney Metrick, wise woman and friend; Keith Miller, Steve Norton, Tony Lee, Big Craig White, Dr. Phil Sherard, Pia Axelson-Butler, and the late (and greatly missed) Gary Smith; Matt Morrissey, John Gragiani, and Courtney Thomas—the "new generation;" and all my other union brothers and sisters, who helped take some of the weight off the shoulders of the President, so that he could finally get his Ph.D.

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DEDICATION

This study is dedicated to R.

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CHAPTER I

INTRODUCTION

Diabasis was a residential treatment center for early episode acutely psychotic young adult clients that operated as part of the San Francisco mental health system in the 1970s. Taking its name from the Greek word for "crossing over," Diabasis viewed and treated psychosis as a potentially transformative developmental crisis and transpersonal experience, rather than as a pathological "disease." The program, founded by the late John Weir Perry, MD, was unique in combining a Jungian orientation with a primarily paraprofessional staff in a medication-free milieu.

This study began with several questions: What was it like to go through a psychotic process at Diabasis? What were the effects of this accepting milieu and of the unique type of individual therapy practiced there? How did its treatment philosophy evolve? Did involvement with Diabasis have long-term impact on its residents and staff? These and other related questions comprised the general direction of a phenomenological investigation, which used both open narrative and semi-structured interviews to explore the subjective experience of people involved with Diabasis.

I became involved in alternative treatment of acute psychosis when I worked as a staff therapist for three years at I-Ward, an innovative program for "first break" clients that functioned as a medication-free ward at the County Hospital in Martinez, California, from 1975 to 1983. I-Ward, like Diabasis, grew out of a research study of alternative approaches to psychosis called the Agnews Project (Rappaport, Hopkins, Hall, Belleza, & Silverman, 1978): I-Ward's founder, Stanley Mayerson, had worked with John Perry on Agnews. As a result of my work at I-Ward, I both observed and facilitated many dramatic recoveries of people in acute psychosis. In undertaking the study described in this dissertation, I hoped to shed more light on the mysterious process of psychosis, which was allowed to express itself freely at both I-Ward and Diabasis. I still work within

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the same county system and it is my clinical opinion that the types of clients who, years ago, were treated on I-Ward, and subsequently recovered, would be diagnosed as schizophrenic and told they have a "brain disease," if they entered our system now.

The study adds to the sparse literature that examines the subjective experience of the psychotic client. It also adds to the barely existing literature that explores the experience of therapists treating such clients in a medication-free setting. In gathering my data, I conducted five in-depth interviews. I interviewed three former staff members and John Perry, the primary founder and developer of Diabasis, to explore their subjective experiences both of the treatment approach and of working with psychotic clients in such a setting. I also interviewed one former resident—the only one I was able to locate—and she serves as the single participant with direct relevance to the subjective experience of going through a psychosis at Diabasis. In addition, I reviewed the Diabasis archives, including 30 patient charts made available to me by John Perry.

In addition to the Agnews Project, studies published over the last few decades (e.g. Bola, 1998; Dabrowski & Aronson, 1964; Goldberg, Klerzman, & Cole, 1965; Karon, 1983; Menninger, 1959, 1999; Matthews, Roper, Mosher, & Menn, 1979; Silverman, 1978; Sullivan, 1953) have presented evidence that some people experiencing acute psychotic episodes, when allowed to undergo the psychotic process in a supportive, medication-free setting, can go on to lead rewarding lives, rather than becoming chronic mental patients. Mainstream psychiatry has dismissed these studies out of hand, usually without addressing any of them directly. Torrey (1988), for example, rejected the validity of all clinically derived evidence as "unscientific" and specifically attacked Sullivan for "personal bias" by claiming that he "almost certainly experienced multiple episodes of schizophrenia" (p. 162). Goodwin (1999) recently described Mosher's work as "simply an interesting description," rather than a "true scientific inquiry," and noted that the argument for alternative (medication-free) treatment "has long been settled by a mass of scientific evidence" (p. 41).

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In discussing my own work at I-Ward, as well as relevant studies, with colleagues, I have often encountered skepticism. Psychiatrists will most frequently argue that our high degree of success on I-Ward should be reinterpreted as an artifact of misdiagnosis. According to this position, all the clients we treated were actually suffering, not from Schizophrenia, but from what is now termed Brief Reactive Psychosis. This argument posits that clients in this diagnostic category are destined to return to normal functioning anyway, so they cannot be used to prove that the treatment in question prevented them from developing into "chronic schizophrenics."

While all I can offer, from my experience at I-Ward, is clinical, anecdotal evidence, the fact is that, for a period of eight years, our therapists were called to the psychiatric emergency screening ward of the hospital whenever somebody without a prior history of psychiatric hospitalization presented with psychotic symptoms. Since we accepted *all* first break clients, not all of them could have been Brief Reactive. Since we were also called to the psychiatric emergency ward whenever a former I-Ward client appeared, we knew that, six months after they had first been admitted, only a small minority of these clients was still presenting with psychotic symptoms. Because of our program, the majority never "earned" a diagnosis of Schizophrenia, which ostensibly can only be given after six months.

However, the Agnews Project, a large-scale, double blind National Institutes of Mental Health (NIMH). study, offers more "scientific" evidence than I-Ward; this evidence undermines both the Brief Reactive interpretation and Torrey's dismissal. The project was carried out at Agnews State Hospital in San Jose, California, from 1969 to 1971. Two groups of randomly assigned acutely psychotic men were treated in a supportive milieu. The first group received chlorpromazine, the second a placebo. Three years after hospital treatment, the placebo group had greater long-term improvement, less pathology, fewer re-hospitalizations, and better long-term functioning in the community.

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In addition, participants treated with medication at Agnews had roughly the same rate of recidivism as the national average in mental hospitals (73%), while the placebo group showed only 8% recidivism. Since the study was carefully controlled for observer bias and rigorously randomized, it is statistically improbable that most of the participants in the one group were suffering from Brief Reactive Psychosis, while the participants in the other were "truly schizophrenic."

The Agnews Project results demonstrated that, over the long term, at least some psychotic patients do better without the use of anti-psychotic medication. Nevertheless, to my knowledge, no acute psychiatric wards or residential facilities operating in the United States, as of February 2002, openly offer such treatment. Perry's medication-free milieu design, as used both at Agnews and at Diabasis, has, despite its remarkable efficacy in treating acute psychosis in some clinical settings, been ignored by the psychiatric community.

The Agnews Project was a high quality quantitative study, both approved and funded by NIMH. Nevertheless, when the Agnews State Hospital Research Department sought to publish the findings, their article was rejected by four major psychiatric journals, despite being approved for publication by the peer review panels assembled by each of the journals. Eventually published in 1978 in *International Pharmacopsychiatry*, it received little attention in the United States (John Perry, personal communication, January 20, 1998).

Potential Audience for and Impact of This Study

The results of the Agnews Project, as well as other quantitative studies (discussed below) that contradict the biopsychiatric model of psychosis, have never been considered relevant by the psychiatric establishment. Mosher, who was the first Chief of NIMH's Center for Studies of Schizophrenia, began the best known of these studies, the Soteria

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Project, in 1970 and has continued to publish analyses of the results. In a recent article he stated that the Soteria study "has been treated as if it never existed" and described "25 years of swimming upriver against the prevailing biological zeitgeist" (Mosher and Bola, 2000, p. 68).

In designing my study, I was aware that a small qualitative and archival follow-up study would have questionable significance for, and little impact on, mainstream psychiatric practitioners, especially given their continuing penchant for valuing large quantitative studies that support the biopsychiatry position. However, my personal experience with clinicians who are open to alternative approaches, particularly those with psychodynamic, existential, humanistic, and transpersonal orientations, led me to believe that they might find an historical and phenomenological case study of an alternative treatment program more compelling than a quantitative study.

Many of these practitioners have little exposure to non-medical treatment models for psychosis. Especially in the current climate, when the psychoses are viewed as largely biomedical disorders with few functional and no transpersonal elements, such research may serve to assist clinicians in being more open to evolving new theories and treatments (Lukoff & Everest, 1985). As a result, the current study could be of interest to this group, as well as to practitioners of alternative medicine, pastoral counselors, ethnic healers, interested laypersons, and the growing consumer/survivor movement.

The primary method I employed in this study was the analysis of transcripts of interviews, as well as of the briefer descriptions included in archival charts. Dating back to both William James and Freud, there is a venerable tradition in psychology that has relied on detailed descriptive analysis of individual case material in the development of both theory and practice. This approach to studying psychosis was favored by Jung (1953) because he believed that the client's subjective experience contained a wealth of untapped and valuable information about the process of psychosis. In fact, Jung's own (1960) early

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contribution to the understanding and treatment of psychosis adheres closely to this tradition.

In his "Forward" to Perry's (1953) book, *The Self in Psychotic Process*, Jung emphasized that

> psychiatry has entirely neglected the study of the psychotic mind, in spite of the fact that an investigation of this kind is not only important from a merely scientific and theoretical point of view, but also from the standpoint of practical therapy. Therefore, I welcome Dr. Perry's book as a messenger of a time when the psyche of the mental patient will receive the interest it deserves....The reader should not be mislead by the current prejudice that I produce nothing but theories. My so-called "theories" are not figments but facts that can be verified, if one only takes the trouble, as the author has done with so much success, to listen to the patient, to give him the credit—that is humanly so important—for meaning something by what he says, and to encourage him to express himself as much as he possibly can. As the author has shown, drawing, painting, and other methods are sometimes of inestimable value, inasmuch as they complement and amplify verbal expression. (p. v)

I believe that a qualitative study, which attends carefully to the actual experiences of the acutely psychotic person and those who engage deeply with her or him, can contribute more depth to current theoretical understandings of psychosis. Perry's original theory grew out of this kind of attention to subjective experience and further development of this theory requires a return to the *prima materia* of psychotic experience, so it may reveal its still hidden meanings to us.

Given these considerations, I designed a qualitative study that includes both phenomenological and archival material. I intentionally avoided objectifying the process of psychosis or the individuals who went through this process at Diabasis.

Because this study is concerned with treatment for acute psychosis, the following literature review will briefly describe the "medical model" which dominates the field. It will then describe theories regarding psychosis and its treatment that have emerged to challenge the medical model. These include John Perry's Jungian-oriented model, as well as several competing and complementary perspectives on theory, diagnosis, and

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treatment. The literature review will also place the question of the nature of psychosis in an expanded context by drawing on sources outside the field of psychology and psychiatry, since anthropology, philosophy, and social theory also address the subject of psychosis and alternative treatment in relevant ways.

The Medical Model of Psychosis

Within the mental health field, the current diagnostic categories for psychosis as described in the *Diagnostic and Statistical Manual of Mental Disorders-IV* (American Psychiatric Association [APA], 1994) reflect the dominant theoretical paradigm advanced by biopsychiatry. This model of psychosis has relied heavily on genetic, biochemical, and brain imaging research for support (see e. g. Torrey, 1988, 1994, 1997; Wender, 1981; Whitaker, 2002). Recent research has focused, for example, on re-framing diagnostic categories so that they would each correspond to a "discrete pathophysiologic condition" (Ratakonda, Gorman, Yale, & Amador, 1998, p.75); using statistical analyses of "twin cohorts" to assert genetic causation (Cannon, Kaprio, Lonnnqvist, Huttunen, & Koskenvuo, 1998); and comparing brain (PET) scans of "people with and without schizophrenia" (NARSAD Research, 1996, p. 9).

Whitaker (2002) has described the controversy involving recent studies that administered medications that worsen psychotic symptoms to "diagnosed schizophrenics," as well as those in which neuroleptic medication was administered to adolescent relatives who do not meet the DSM-IV criteria for Schizophrenia. Researchers have justified these "designs" as necessary to "provide a better model of schizophrenia" (p. 242). Despite this controversy, Harvard Medical School recently announced that "research is about to begin on the prophylactic drug treatment of genetically vulnerable relatives to [*sic*] schizophrenics who may be showing early signs of the disease" ("How Schizophrenia Develops," 2001, p. 3.). In contrast, as Mosher (1999) has noted, research

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involving an experimental group that does *not* receive neuroleptic medication "might not receive...approval for protection of human subjects as it would involve withholding a known effective treatment..." (p. 149).

In the medical model, psychodynamic and social variables are viewed as having negligible significance in the etiology of the psychoses, except in the Brief Reactive diagnosis. Neuroleptic medication is the treatment of choice during all phases of Schizophreniform, Schizo-Affective, Bi-Polar Disorder, and Schizophrenia. While severely downplaying developmental and family systems factors in the etiology of psychosis, the model gives no credence whatsoever to the possibility of spiritual or transpersonal processes being involved (Grof, 1986; Lukoff & Everest, 1985). In most cases, the prognosis for psychotic clients is considered poor, with the expectation that the disorder will manifest itself in a chronic pattern of lifelong vulnerability to decompensation during times of sufficient stress (Beard, Malamud, & Rossman, 1978; Falloon, Boyd, & McGill, 1984; NARSAD Research, 1996; Vaughn & Leff, 1976.)

Even psychiatrists who question the evidence for genetic and biochemical causation argue that medication is vital in treating psychosis (Fisher & Greenberg, 1989; Bower, 2001). Many psychiatrists believe that not prescribing such medications constitutes malpractice (Torrey, 1988; O'Keefe, 1994). In comparison with medication, psychotherapy is deemed either ineffective or dangerous (Torrey, 1988) and rarely utilized, either during the acute phase or, later, during the chronic phase (Kety & Matthysse, 1988; Maxmen, 1986; O'Keefe, 1994). Current treatment recommendations from NIMH advise against using psychodynamic psychotherapy in particular; "supportive" counseling, however, is recommended to "foster adjustment" and medication compliance and to teach "problem-solving and social-coping skills" (reported in Bower, 2001, p.269).

In addition to its biomedical orientation, the medical model views practitioners as expert authorities and those they treat as patients (Rogers, 1977; Mosher, 1999). It

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places all authority in the hands of practitioners and justifies forced neuroleptic medication, involuntary hospitalizations, and such practices as electro-convulsive therapy (ECT), seclusion, and restraints (Breggin, 1991). Psychiatrists have continued to prescribe neuroleptics even though evidence that they cause largely irreversible and untreatable neurological disorders in a large percentage of users has been in print since 1973. These disorders results in symptoms that themselves cause a person to appear "crazy," such as uncontrollable grimacing, twitching, and sense of "inner torture" that makes it impossible to sit still (Breggin, 1994). For recent annotated bibliographies of studies that demonstrate the brain-damaging effects of neuroleptics, see Mosher (n.d.) and Support Coalition International (1999).

As Mosher (n.d.; see also Mosher and Bola, 2000), Breggin (1991), and Whitaker (2002) have demonstrated, compelling evidence from a number of research studies not involving alternative treatment indicate that the biopsychiatry model is faulty. These include, for example, longitudinal studies demonstrating that complete remission is highest among discharged psychiatric patients who do not continue to take medication (e.g. Harding, 1987a; 1987b; Harding & Zahniser, 1994) and World Health Organization studies showing more positive long-term outcomes for "schizophrenics" in poor countries (where neuroleptics are rarely available) than in the U.S. (Whitaker, 2002).

Torrey (1988, 1994, 1997), the best-known popularizer of the medical model of Schizophrenia, criticizes the same model as it is applied to some other forms of so-called "mental illness." Drawing out the logical consequences of the reductionist, mechanistic, and dualist scientific paradigm which underlies biomedical theory in general, he sharply separates "problems in living" from biologically based "illnesses," among which he includes Schizophrenia and Bi-Polar Disorder. This stance has pitted those in need of services and scarce resources into competing groups. Several states now have legislation, sponsored by the psychiatric establishment, that has created a legal classification—the Severely and Persistently Mentally Ill—whose members are now receiving most of the

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available federal, state, and county funds for mental health services (Torrey, 1997). Torrey's work, which insists that families have no part in the etiology of Schizophrenia and argues for neurological rather than psychological treatment, has supported the development of a large, politically powerful, movement of "family members," the National Alliance for the Mentally Ill (NAMI).

The Jungian Theory of Psychosis

While the medical model has dominated the discourse regarding psychosis since World War II, competing theories regarding psychosis and its treatment have also emerged to challenge it. In the late 1940s and early 1950s, following both extensive work with psychotic patients and Jungian analytical training in Zurich, Perry (1953, 1962, 1970, 1971, 1974a, 1974b, 1976, 1986, 1999; see also Bray & Daab, 1992) formulated his theory of psychosis. Perry's innovative approach and paradigm evolved from and extended Jung's own major contribution (1960) to the understanding of psychosis. It also evolved from Boisen's (1936) work on the content of psychotic processes; according to Perry (1976), Boisen had "Jungian inclinations" (p.7) and "established that there was a groundplan to the acute episode" (p. 12). Jung, Boisen, and Perry all proceeded from the assumption that powerful spiritual or archetypal forces operate in the human psyche. In his "Forward" to Perry's first book, Jung (1953) recognized Perry's work on psychosis as an extension of his own groundbreaking work at the turn of the century.

Perry argued that acute psychoses are upheavals needed to redress a pre-psychotic schizoid state, which he referred to as the "chronically regressed personality." This personality results from a "central injury," which occurs because the developing individual is overly immersed in a family situation where the archetypal complexes associated with parental figures are negatively overpowering in their effects. Perry also

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argued that these forces utilize the Self, or archetype of the Center, to contain and integrate an experience of renewal of the psyche, which he called the Renewal Process.

Both theory and clinical experience led Perry to view psychosis as an auspicious developmental and transpersonal crisis. If treated as a Renewal Process, he argued, the acute phase could serve to facilitate a higher level of integration, rather than progress to a full schizophrenic condition. If medication is not used to suppress or abort this process, Perry believed, as did Jung (1953), that a person could heal through contact with others who valued and supported the person's encounter with the archetypal realm.

Perry (1970) also contributed to clinical understanding of how the archetypes actually operate in the psyche by explaining their role in object relations and emotion. He noted that,

> since the term archetype seems to bring down upon the average American a cloud of befuddlement and murky connotations of Plato and Augustine, in my dealings with professional associates I have come to use the term affect-image instead for the archetypal phenomena that we encounter in therapy. The term has the advantage of meaning exactly what it says and rendering its own definition. (p. 9)

Perry tested his approach at the Agnews Project (Rappaport et al., 1978)—the research project on the treatment of acute psychosis without medication discussed above—and, subsequently, at Diabasis. While other Jungian analysts (including Levene [1978], who worked with Perry to found Diabasis) have occasionally presented case histories involving work with individual psychotic clients (e.g. Dallet, 1988; see also Sandner & Beebe, 1985), Perry remains, to this day, the major contributor to Jungian theory regarding psychosis (Sandner & Beebe, 1985; J. & R. Henderson, 1997). In his last book (1999), published the month he died, he expanded his theoretical work on psychosis even further and included, as appendices, brief reports on the Diabasis projects, noting that "85 percent of the clients in Diabasis I not only improved, with no medication, but most went on growing after leaving us" (p. 147). He told me that he hoped the book would "stir up controversy in the late '90s, as *Far Side of Madness* did in the late '70s,

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so, once again, people will struggle with these questions" (personal communication, August 10, 1998).

Early Non-Jungian Alternatives to the Medical Model

Burton (1960) traced the history of non-Jungian psychoanalytic approaches to psychosis from the work of Paul Federn and the early work of Wilhelm Reich to the work of Menninger and the Interpersonal psychoanalysts. Menninger (Menninger, Maymen, & Pruyser, 1963; see also Menninger, 1959) coined the term "weller than well" to describe the condition of some of his patients who had successfully traversed a psychiatric "sickness." Even in 1988, in a letter to Szasz (1998-2000), Menninger described being "disturbed" by the current state of treatment and noted that, while he "didn't know why" some patients got "weller than well...it seemed to some of us that the kind of 'sickness' we had seen was a kind of conversion experience, like trimming a fruit tree...." (p. 1).

The work of Interpersonal psychoanalysts included the legendary innovations of Fromm-Reichmann (1948) at Chestnut Lodge. Sullivan (1953, 1962), like Fromm-Reichmann, pioneered the use of milieu therapy for people in psychotic crises, noting that the process can "reorganize whole masses of life experience" (1962, p. 20). Havens (quoted in Lionells, 2000b) called Sullivan "the major underground influence in American psychoanalysis" (p. 3). Sullivan also exerted a major influence on forms of alternative treatment outside of psychoanalysis: Mosher (1999) explicitly described Sullivan's influence on his work, while Perry only noted it in passing (e.g. 1974).

Most psychoanalytic treatment has focused on work with "post-acute" phases of psychosis. In the 1960s, clinicians such as Boyer (1983), Giovacchini (Boyer & Giovacchini, 1967, 1990), and Searles (1961) expanded psychoanalytic approaches to such treatment. Their work was considered controversial and even "excoriated as heretical" within the psychoanalytic community (Boyer and Giovacchini, 1990). Despite

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ongoing controversy, Karon and VandenBos (1981) reported positive results from a major study done on the use of psychodynamic psychotherapy with a large number of schizophrenic clients and Pao (1979) and his colleagues continued to work with psychotic clients at Chestnut Lodge. Gabbard (1994) reviewed the then-current status of psychoanalytically oriented psychiatric treatment for psychosis and Bower (2001) described a recent course of psychotherapy with a psychotic client at Chestnut Lodge.

However, according to the therapist involved in the case described by Bower, most residents at Chestnut Lodge (which closed as a result of bankruptcy in 2001) had been medicated for at least the last 15 years (Ann Alaoglu, personal communication, February 22, 2002). The Menninger Clinic is also experiencing serious financial difficulties; Munich, the Clinic's Medical Director (quoted in Hooper, 2000) noted that the Clinic's problems have resulted not only from current financial imperatives, oriented toward "rapid symptom reduction," but from the waning popularity of psychoanalysis. When the Clinic was in its heyday, most academic psychiatry departments were headed by psychoanalysts; today, "they are mainly psychopharmacologists and social psychiatrists" (p. 3). While the Menninger Clinic uses psychiatric medications (as did Chestnut Lodge), Munich equated them to "putting a cast on a broken leg. They don't in and of themselves fix the broken leg" (p. 2).

Mosher (1999) and Lionells (2000a) also noted a relationship between the dominance of biopsychiatry and the now-subordinate status of psychoanalysis within psychiatry. According to Whitaker (2002), criticisms of early biopsychiatric practices, such as the use of ECT, came primarily from psychoanalysts. Illustrating this point, he quoted Sullivan's statement:

> These sundry practices...produce "beneficial" results by reducing the patient's capacity for being human. The philosophy is something to the effect that it is better to be a contented imbecile than a schizophrenic. If it were not for the fact that schizophrenics can and do recover; and that some extraordinarily gifted, and therefore socially significant, people suffer schizophrenic episodes, I would not feel so bitter about the...situation...." (p.98-99)

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Several non-psychoanalytic alternatives also emerged to challenge the medical model of psychosis. Rogers (1977; Stevens & Rogers, 1967) extended his client-centered therapy to include work with hospitalized "chronic schizophrenics." Reporting on doing therapy with this population, within the context of a research project, Rogers and his colleagues emphasized that "successful" therapy required practitioners with an exceptional degree of those same qualities needed for successful client-centered therapy in general. In discussing the political aspects of the client-centered paradigm, Rogers (1977) described Perry's work at Diabasis in depth and cited it as a quintessential example of what he called the "quiet revolution."

Bateson (1972) brought his training as an anthropologist and his interest in systems theory to bear on human communications problems, of which he saw schizophrenia as a paradigm case. In studying the communication patterns of individual schizophrenics, as well as the communication patterns within their families, Bateson and his colleagues developed the theory of the "double bind," which they argued was a necessary, if not sufficient, condition for "creating schizophrenia" (Sluzki & Ransom, 1976). They saw the double bind as the primary (unconscious) tactic of an anxious "schizophrenogenic" mother and described the child who responds by becoming schizophrenic as the "identified patient" in what is actually a highly dysfunctional family system. Their work influenced the specialties of both Family Therapy and Brief Therapy (Hoffman, 1981), especially in the person of Haley, one of Bateson's colleagues; Haley's influential *Leaving Home* (1997) addressed the developmental challenge of separation from the family faced by "disturbed young people."

The Scottish psychiatrist R. D. Laing, the most famous spokesperson for the "antipsychiatry" movement of the 1960s and 1970s, also placed strong emphasis on the role played by the interpersonal and familial matrix of communication in creating individuals with psychotic dysfunction (Boyers and Orrill, 1969; Laing, 1959; Laing & Esterson, 1964). In addition (1967), he argued that, our society, thoroughly insane itself,

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is capable of driving the sanest among us mad. His background in phenomenological and existential psychiatry (May, Angel, & Ellenberger, 1958) inspired his careful attention to the lived reality of psychotic experience, which developed into his later critique of modern Western society.

At Kingsley Hall, in London, Laing pioneered his phenomenological approach to "treating" psychosis. Goldblatt (1995) described his training at Kingsley Hall, where he was taught the practice of "being with" people undergoing a psychotic process; he learned that, in a safe and supportive environment, "simple human contact" that does not interfere with the person's process is often sufficient to facilitate the person's "return to a stable state" (p. 158).

Although not identified as a Jungian, Laing (1959) cited Jung as an influence, noting, in his first book, *The Divided Self*, that his work "provides striking confirmation of Jung's statement that the schizophrenic ceases to be schizophrenic when he meets someone by whom he feels understood" (p. 165). He also included Perry's *The Self in Psychotic Process*, which was published in 1953, in the bibliography of *The Divided Self*, although I have never found any discussion of Perry's work in Laing's writings. Laing (1967) also referred to archetypal forces operating in psychotic states and acknowledged the role of the "transcendental" realm in psychosis, arguing that

> true sanity entails, in one way or another, the dissolution of the normal ego, that false self competently adjusted to our alienated social reality; the emergence of the "inner" archetypal mediators of divine power, and through this death a rebirth, and the eventual re-establishment of a new kind of ego-functioning, the ego now being the servant of the divine, no longer its betrayer (p. 145).

Mosher's Soteria Project (1974, 1992, 1994, 1995, 1999, 2000; see also Gunderson & Mosher, 1975; Matthews Roper, Mosher, & Menn, 1979) grew out a variety of influences, including existential and phenomenological psychology, the work of Sullivan, and the year Mosher spent at Laing's Kingsley Hall. Soteria House, a small, home-like treatment program located in the San Francisco Bay Area, opened in 1971—the

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"first in a series of successors to Kingsley Hall" and by far the best documented, researched, and influential of the alternative treatment centers that existed in the United States. Soteria closed in 1983; its sister house, Emanon, operated from 1975 to 1980. In direct reaction to problems at Kingsley Hall, Mosher attempted to create a program that would "conform to neighborhood social norms" and the program closed only because it lost its funding (1995, p. 111).

Soteria also used a model of "being with" residents in acute psychosis but, despite describing a variety of influences on his work, Mosher practiced "being with" as an atheoretical "stance." This involved "an attempt to understand and share the psychotic person's experience, and one's reactions to it, without judging, labeling, derogating, or invalidating it" (1995, p. 113), within the container of a "safe, warm, supportive, unhurried, tolerant, and nonintrusive social environment" (p. 112). Soteria's staff was encouraged to develop long-term non-sexual relationships with clients, who were viewed as peers; Mosher noted that staff were effective to the degree that they were "psychologically strong, tolerant, flexible, positive, and enthusiastic," rather than professionally trained (p. 121). Findings from the Soteria research indicate that long-term outcomes for clients were most positive during a period when almost no residents took medication and the program included a social network—made up of current and former staff, "friends," and former residents—that had spontaneously grown up around it.

Mosher (1992) described in detail what actually occurred at Soteria, as well as its structure and treatment philosophy. This document included first-person accounts of staff members, which emphasize that much of the "work" involved simply relating to residents as "spaced out" peers and interacting with them in a spontaneous and accepting manner. Although ostensibly not doing "therapy," Soteria's staff often held long "vigils" (descriptions of which are also included) for particularly acute residents. These usually involved several staff—both "professional" and "paraprofessional"— working with a single resident, sometimes attempting "to take her back to the stimulus which spun her

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off into madness" (p. 26). Mosher noted that some of the founding members of the Soteria Project had worked on the Agnews Project, but that the "vigil" (which originally involved an enclosed space) was the only Agnews "technique" used there. All Soteria residents given vigils improved dramatically and the practice of formal vigil eventually "matured" into the more generalized practice of "being with," since space at Soteria was by nature already "enclosed."

Mosher's influence, as well as his active advocacy for alternative treatment, has continued into the present, particularly in Europe, where "Soteria Houses" still exist (see e.g. Ciompi et al., 1995) In recent years, he has focused on developing Soteria-like treatment centers for the "chronically and persistently mentally ill" (Mosher & Burti, 1994; Mosher, 1999). His data analysis of the Soteria research, which included comparison groups of patients admitted to local psychiatric wards, was completed in 1992. Recently, supported by another NIMH grant, Bola (1998) did a "multivariate reanalysis" of the Soteria study, noting that his

> findings, that antipsychotic medication use exerts a negative influence on both composite outcome and days of 24-hour care (with the effects of outcome on medication use controlled through simultaneous equation methods), stand in contrast to a substantial body of literature in the field. (p. 3)

Bola and Mosher (2001) recently presented this work at the World Psychiatric Association's International Congress and have an article forthcoming (Bola & Mosher, in press) in *Schizophrenia Bulletin*.

Influenced by Laing, Bateson, and Jung, Mayerson (cited in O'Keefe, 1995) participated in the Agnews Project with Perry and in the Soteria Project with Mosher. He continued his work as founder of I-Ward, where he promoted a unique approach to acute psychosis rooted in intense family and milieu therapy. In his private practice, he refused to work with families who agreed with the medical model and accepted only clients fully committed to the belief that full recovery from "schizophrenia" is possible.

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Burch House (Goldblatt, 1995; Morissey, 1996), modeled on Laing's Kingsley Hall, opened in New Hampshire in 1978 and was the longest-lived alternative treatment program in the United States. Founded by David Goldblatt and Catherine Burch Symmes, Burch House focused on the healing effect of "participatory community emphasizing compassionate peer relationships and a wholesome lifestyle" (Morrissey, p. 7). Unfortunately, like Chestnut Lodge, it closed in 2001; as Morrissey (n.d.) noted,

> those of us who are fortunate to understand what the closing of this house means, and more specifically...those who have happened to pass through the house over the years...experience this closing as perhaps the most significant defeat in a long line of attempts to challenge psychiatric hegemony." (p.1)

Challenges to the Medical Model from Outside the Field

Research on altered states of consciousness, meditation, religious experience, and psychic phenomena has challenged the medical model, by demonstrating that non-ordinary states of consciousness may have dimensions not easily reducible to direct biochemical causation (Krippner, 1977, 1980; Monroe, 1971; Targ & Hararay, 1984; Tart, 1975, 1977). Grof's (1976, 1980, 1985) research on hallucinogenic drugs also contributed to a reevaluation of the psychotic process. Grof's subjects experienced LSD-induced psychotic-like hallucinations as positive and psychologically transformative, and reported gleaning deep personal meaning and valuable inner knowledge from them.

Cross-cultural studies and anthropology point toward a different etiology and significance for psychosis than that assumed by the Western medical model. Spiritual forces have been, and still are, postulated as the cause of psychotic states by traditional societies (Eliade, 1959; Jung, 1971) and widespread belief in spiritual causation for psychosis continues to exist in contemporary developing countries (Inge-Heinze, 1985; Koss, 1987), where shamans and *curanderos* serve as counterparts to the Western psychotherapist (Campbell, 1984; Harner, 1980, Maduro, 1983).

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Shamans themselves have often been initiated by a psychotic-like episode which enables them later to traverse inner spiritual territory to assist their patients (Castaneda, 1971; Greeley, 1974; Lukoff, 1990-1991; Jung, 1965; Silverman, 1968; Von Franz, 1975; Walsh, 1990). Von Franz, Jung's biographer, compares his mid-life experience of seemingly-psychotic immersion in the collective unconscious to that of a shaman, relating that Jung saw himself as an

> obstetrician, so to speak, or midwife, assisting in bringing into the light of day a natural inner process, the process of coming into one's self....In this respect [his] work resembled that of the old shamans or medicine men among the primitive peoples. The shaman or medicine man also seeks with his own means (trance, oracles, etc.) to learn what the "spirits," that is, the activated unconscious or certain complexes, want from the person suffering, so that they can be propitiated through appropriate rituals, expiatory rites, sacrifices, etc.; or driven away if these "spirits" are alien to the personality. The shaman is able to do this because, during his initiation ordeal, he himself struggled with the spirit world, the unconscious, and has come to terms with it, so that he has learned to understand the language of spirits....As Mircea Eliade has pointed out, the shaman himself does not heal; he mediates the healing confrontation of the patient with the divine powers. (pp. 65-66)

Lukoff (1990-91) has also described his experience of "divine madness" in terms of a "shamanic initiatory crisis." This initiation set him on his path as a healer, via the profession of clinical psychology.

Social theorists, such as Foucault (1965, 1976), Goffman (1961), and Scheff (1984), have also explored the fundamental nature of madness. Because they criticize Western medical science's theoretical model, placing the bio-medical paradigm in a larger context, where alternatives may be taken more seriously, their work offers supportive evidence for alternative treatment models. Foucault's "archeology of knowledge" demonstrated that, since the birth of the "Age of Reason," treatment for psychosis has been used to create a demarcation between the rational and the irrational that serves the interests of those with political power. Goffman described the "degradation rituals" used in mental hospitals that force patients to accept a role that is permanently stigmatizing. Scheff used "labeling theory" to argue that "mental illness" is simply a social category

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used to describe deviant behavior, which is then subject to "treatment" that is actually a form of social control.

Two prominent psychiatrists, Szasz (1961, 1994, 2001) and Breggin (1991, 1994, 1997, 2002; Breggin and Cohen, 1999), have also written from a social-historical perspective. Neither criticized the mind-body dualism of the medical model, but both have drawn the line between medical illnesses and "problems in living" differently than Torrey (1988). Szasz, a libertarian, has argued that mental illness is a "myth" used to justify draconian treatment measures which would otherwise be unconstitutional. While demanding that the entire psychiatric establishment be abolished, he also demanded an end to the insanity defense and psychiatric disability payments, arguing that anyone without an "organic" psychosis should be held entirely responsible for her or his actions. Breggin, one of the earliest and most effective critics of ECT (1979) argued that all psychiatric medication is both unnecessary and dangerous. He attacked both genetic and biochemical research as poorly designed and as claiming findings unsupported by its own evidence, arguing that there is no scientific basis for believing that the non-organic psychoses involve a physiological dimension (1991). However, he defined all so-called "mental illness" as "psycho-spiritual" and has been a staunch supporter of psychotherapy, spiritual and consumer-controlled approaches to treatment, and progressive movements.

Current Alternatives to the Medical Model

Within the fields of psychology and psychiatry, the meaning of madness, and how society responds to it, continue to attract the attention of a small minority of practitioners. Alternate treatment modalities are still used by a handful of clinicians in the United States who exert an, albeit minor, influence on the field of clinical practice at large. (Alternative treatment is much more popular and influential in Europe, but European

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alternatives have had little influence on American clinical practice, so I will not review them.) In addition, consumer-oriented movements are generating interest in alternatives to medication and hospitalization. Most of these approaches emphasize that, given the appropriate treatment, clients can experience complete "recovery," even from long-term "chronic schizophrenia."

Breggin (1991, 1994, 1997, 2002; Breggin and Cohen, 1999) is the most prominent current advocate of alternatives to biopsychiatry. Through his books, workshops, and public appearances, he continues to promote empathic relationship as the treatment of choice for psychotic disorders. Unfortunately, both he and his associates at the San Joaquin Therapy Center (Breggin, 2002) seem only to offer out-patient psychotherapy.

Podvoll (1990), also a psychiatrist, brought a Tibetan Buddhist perspective to the healing of madness. He emphasized the continuity between normal and psychotic states—arguing that "if you have a mind, it can go mad"—and that recovery from psychosis depends upon expanding the "islands of clarity" that exist within the psychotic state. His Windhorse Project involved members of a Buddhist community, associated with the Naropa Institute, as paraprofessional therapists in an alternative community setting, primarily oriented towards individual "schizophrenics" who have already had extensive psychiatric treatment. The program, currently under the direction of Fortuna (1995), now operates in both Colorado and Massachusetts, as well as in Europe, and employs "treatment teams" that include professional psychotherapists. Windhorse houses most clients in individual apartments with a "staff housemate" (Windhorse Associates, n.d.), so it cannot provide, as did Diabasis and Soteria, the kind of residential facility usually necessary to treat early episode acute psychosis without medication.

Another psychiatrist, Nelson (1994), influenced by the work of Grof (1976, 1980, 1985), as well as by the philosophers Ken Wilbur and Michael Washburn, described psychotic experience as one variety of Altered States of Consciousness (ASCs). Using the chakra system to differentiate between various kinds of psychotic ASCs, he has

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attempted to create a holistic diagnostic and prescriptive system which downplays the use of medication and allows the client to control the dosage of any medication that is used. Nelson described a comprehensive treatment for first break psychoses, which includes an initial medication-free observation period to determine if the process can continue in a "positive" direction without medication, but he did not reveal, at least in his book, if and where he actually practices this.

Mindell (1988), initially trained in Zurich as a Jungian analyst, has created a system called Process Oriented Psychology (POP), which incorporates many other influences, including Gestalt Therapy, shamanism, communication theory, and Taoism. Mindell trains POP practitioners to work with what he calls "extreme states," which include the psychoses, and has described his own work with "chronic schizophrenics." He explicitly countered the arguments of Torrey and insisted that every extreme state client with whom he has worked has emerged out of their psychosis, at least temporarily, within three days. POP involves a long training process in which the practitioner learns to track, simultaneously, a large variety of "signals" in her client and herself, and to become comfortable with whatever emerges in her, or her client's, process.

As I noted above, Lukoff (1990-91; see also Lukoff & Everest, 1985), a clinical psychologist who has done innovative, holistically-oriented work with psychotic patients in traditional institutional settings (Lukoff, Wallace, Liberman, & Burke, 1986), wrote about his own experience of "divine madness" in terms of a "shamanic initiatory crisis." Shorto (1999a, 1999b) described Lukoff's current work as a consultant to people who have been through such experiences, as well as his leadership in developing the DSM-IV category of "Religious or Spiritual Problem" (originally proposed as "Mystical Experience with Psychotic Features" [Lukoff, 1985]). As Shorto noted,

> this category...while largely symbolic, since it is not a billable diagnosis, has been like a hole punched through a wall...and was heralded [in the press] as a sign that the field of psychiatry, traditionally so narrowly focused on the biomedical model,

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> was opening itself up to religious experience...[Lukoff now] lectures to colleagues on the historic implications of this change. (p. 17)

Fitzpatrick (O'Keefe, 1994) pioneered the use of neo-Reichian bioenergetic treatment in a community setting for "severely disturbed individuals," most of whom seem to have been "formerly institutionalized and medicated 'back ward patients'" (p. 1). The therapeutic community Hambleceya, which she founded in 1969, still operates in San Diego. The treatment model emphasizes body-based therapies and peer support, leading to complete recovery.

Within various other schools of psychotherapy, rare individual practitioners attempt to apply their respective paradigms to work with psychotic clients. For example, Baker (1986) discussed the successful use of hypnotherapy with people undergoing psychotic states and Perris and Skagerlind (1994) described a cognitive-behavioral treatment program for schizophrenics. Except for the possible exception of Nelson (1994), none of the practitioners I have discussed seem to have access to a 24-hour, residential, acute, "non-medicating" facility for actively psychotic clients. Therefore, they are unable to provide services to clients who require the kind of residential care that was available at Diabasis.

The work of Stan and Christina Grof, in concert with other transpersonal psychologists (in Grof & Grof, 1989), has drawn attention to a particular sub-category of psychotic experience which they have named "spiritual emergency." Their efforts are in line with Lukoff's (1985) initial proposal for a DSM category of Mystical Experience with Psychotic Features and with Sanella's (1987) description of Kundalini "transformation." While such experiences can be spontaneous, they often emerge as a result of intensive spiritual practices. The Grofs, who associate some spiritual emergencies with the Renewal Process described by Perry, have developed a treatment process, usually including their Holotropic Breathwork, which they believe can often be undertaken outside of a residential setting.

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Christina Grof has also been instrumental in forming the Spiritual Emergence Network (SEN) a network of "helpers," mostly non-professional, who are available to work with people seen as undergoing "legitimate" spiritual emergencies. SEN tends to maintain a clear distinction between such "transcendental" states and more common types of psychosis. In this, SEN follows the Grofs, who argue that "transpersonal counseling is not appropriate for conditions of a *clearly* psychotic nature [which] *require* large doses of tranquilizers" (p. xiii, emphasis added).

SEN also operates separately from what is called, variously, the "consumers/ survivors/ex-patients (C/S/Xs)" movement (Auslander, Bustin-Baker. Cousins, Hilton, & Penney, 1998), the "madness network" (Oaks, 2000a), or, more generally, the consumer movement. In a recent ethnology of the C/S/X movement, Duerr (1996) described "psychiatric survivors" as ex-patients who see themselves as having been severely abused by the medical model and who are politically active in opposing standard psychiatric treatment. Survivors have been instrumental in creating peer-support alternatives to psychiatric hospitalization, usually in the form of drop-in centers (O'Keefe, 1994).

"Consumers" oppose specific instances of perceived abuse but tend to focus on preserving access to and funding for treatments currently available, as well as on creating mental health staff positions specifically for ex-patients. However, Duerr (1996) discovered that most consumers, at least in private conversation, agree with survivors in opposing forced treatment, including ECT and court-ordered neuroleptic medication.

A recent development in the interface between service providers and consumers is the growing awareness, arrived at in part under pressure from various social movements, that a large number of people who have psychotic experiences are also survivors of sexual and physical abuse. In a recent review of the literature, Auslander et al. (1998) argued for a 50-80% prevalence rate. These findings are supported by O'Keefe (1994) who interviewed ten women, formerly "back ward schizophrenics" and now in complete recovery, all of whose histories included some form of severe abuse. Auslander et al.

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described a potential shift in both the paradigm and the practice of treating psychosis, where, for example, restraints may be contraindicated as a form of "retraumatization." However, they also argued that "humane" treatment must be extended to all consumers, not just a new elite of trauma survivors, and for a multi-faceted client-controlled treatment model.

Fisher (1994) framed the demands of psychiatric "survivors and consumers" in terms of health care reform, as well as within the "empowerment model" of the larger disability rights and Independent Living movements. Both a psychiatrist and a survivor, Fisher is co-founder, with Laurie Ahern, of the National Empowerment Center (NEC). NEC has pioneered the use of the term "severe emotional distress" (Fisher & Ahern, n.d.) as a replacement for "mental illness" and developed a model of service delivery "based on the philosophy that people can completely recover from mental illness." Their program would replace "case managers" with "personal assistants"—ideally, "recovered" consumers themselves—"who are not afraid to develop a close relationship with the consumer and who believe in the consumers capacity to recover..." (p.2).

All of the consumer-generated alternatives, while rooted in a "recovery model," are oriented toward consumers who are already "in the system." None of them directly address the issue of acute psychosis, during which people may need 24-hour care, or first breaks, during which people might be diverted from the system entirely. My study examined just such an alternative, Diabasis, whose treatment model fostered close relationships and belief in recovery for acutely psychotic young adult clients. It offered the possibility of not only complete recovery, but also positive transformation and development, subsequent to an initial psychotic break. My study asked whether combining a Jungian orientation with a primarily paraprofessional staff in a medication-free milieu did, and could still, foster such recovery.

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CHAPTER II

METHODS

Given that the events and experiences which constitute the subject matter of this study happened more than 20 years ago, I chose to employ interview and archival research approaches, since these qualitative methods lend themselves well to a study that seeks to examine, retrospectively, a multi-faceted phenomenon. I am only able to imply, rather than measure, the efficacy of the treatment at Diabasis, since quantitative evidence cannot be derived from an analysis of subjective and archival data. Unfortunately, Diabasis had no funding for a formal research or follow-up component, so no such component existed. In addition, as I discussed in the Introduction, I believe that a qualitative research design is appropriate for this study, since it reflects the nature of the material and will appeal to my intended audience. John Perry (personal communication, Nov. 10, 1990) agreed that a qualitative follow-up study of Diabasis would also be most significant and appropriate for the further evolution of a Jungian theory of psychosis.

I employed both a phenomenological interview research design and an archival analysis of client charts, in order to comprehend the experience of both residents and staff at Diabasis as a complex unity. Polkinghorne (1989) has named this multi-methodological approach "triangulation." Wertz (1984) has argued that, within the parameters of phenomenological psychology, it is appropriate to develop unique designs in response to individual areas of investigation. Hence the present study represents only one possible variation of a phenomenological design, including specific methods of data collection and organization, as well as analytical procedures.

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Participants

I interviewed five participants, all of whom I contacted through personal referral, since my committee members and I determined that other sources of contact would be either ineffective (advertising) or inaccessible (government records). I contacted 20 former Diabasis staff but only one was able to refer me to a former resident. All interviews occurred approximately 20 years after the participants were involved with Diabasis. All of the interviews were tape-recorded and none of the participants were paid. All participants signed an Informed Consent Form (see Appendix A).

I have chosen to use initials to protect the confidentiality of four of my participants. They included R., the one former Diabasis House resident I was able to contact: a woman and, at the time of the interview, an artist. Three participants were former staff at Diabasis: one man, A., a licensed psychologist who is currently director of a large mental health services agency, and two women: B., currently a writer and community activist, and J., currently a licensed psychotherapist. I interviewed these participants one time each and each interview lasted an average of two hours. The final interview participant was the originator of the Diabasis project: John Weir Perry, MD, a prominent Jungian analyst and prolific author. I conducted two formal taped interviews with Dr. Perry, of about two hours each; we also spoke informally numerous times during the course of my research. Dr. Perry, who was a member of my original dissertation committee, agreed to be identified by name in this study.

Design and Procedures

The main portion of the study drew on phenomenological methods of qualitative data collection and analysis. Each interview elicited an initial open-ended narrative, in response to the general question: "What was your subjective experience of being at Diabasis?" I encouraged each participant to take as much time as necessary to ponder,

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remember, and respond in any sequence that emerged naturally as they verbally expressed the myriad meanings and subjective experiences associated with Diabasis. Yow (1994) has noted that this qualitative approach "allows the researcher to give the participant leeway to answer as she or he chooses, to attribute meanings to the experiences under discussion, and to interpret topics. In this way new hypotheses may be generated" (pp. 5-6). Following each participant's open narrative, I conducted a focused, semi-structured interview to assure a comprehensive account. During this, I asked several specific questions, guided by an interview schedule that covered significant areas possibly not included in the narrative (see Appendix B).

I asked one participant, John Perry, additional questions (see Appendix B)—for example, about his experiences prior to founding the program—that attempted to elicit data relevant to the development of the unique treatment modality used at Diabasis. To supplement the interviews, Dr. Perry also provided unpublished written narrative material, in the form of a memoir, which he hoped would add more detail to his verbal description of the place of Diabasis in the history of Jungian psychology.

I gathered additional data by reviewing archival material, consisting of the treatment charts of 30 residents of the Diabasis program, which John Perry released to me for review. The charts include daily progress notes recorded by Diabasis staff and make available the impressions of some staff members whom I did not interview. These specific 30 charts had survived in John Perry's possession because they had been separated from the rest of the Diabasis charts almost 20 years ago. Perry kept them because he believed they were particularly representative of the clients who had expressed the most archetypal and religious/spiritual content during their psychotic process at Diabasis.

I structured my review of this often-detailed information by asking the same questions I used in the interviews. In this way, meaning units emerged from the chart material that were consistent with what emerged from the scrutiny of the actual interviews.

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The narratives, structured interviews, and chart reviews provided the raw descriptive data that is the foundation of this study. Three phases of processing the raw data completed the analysis and produced an integrated final structure. My approach to data analysis was informed by the work of Kvale (1987), who recommends:

> an *impressionistic, intuitive reading of the transcripts or listening to the tapes; categorization* and coding of the transcripts; *condensation* of the content and structure of the meanings expressed; and *expansion* involving theoretical interpretation, conceptual analysis, drawing in metaphors, and explicating narrative structures. (p. 95)

I first used a winnowing-out process to refine each description by excluding all irrelevant material and including only those statements truly representative of the subjective experience in question. Each of these condensed organizations of data comprised an Individual Phenomenal Description. The process of demarcating meaning involved isolating specific phrases of the descriptions that clearly stood out as "distinguishable moments" (Wertz, 1984). I was usually able to name or differentially identify discreet meaning units in a single sentence. I then discarded as irrelevant any meaning units I judged not to express anything about the phenomenon in question. In combining all the included meaning unit phrases to re-describe the event from the first-person perspective, I stayed as much as possible with the participant's own language.

In the second phase of qualitative processing, acting as the research instrument, I performed a psychological analysis of the Individual Phenomenal Descriptions. I read each Description and thought it through psychologically, in an effort to distill its most revelatory content. During this process, I drew on my 20 years of experience as a practicing Jungian psychotherapist in order to maintain a basic stance of psychological reflection, utilizing such processes as empathy, magnification, and amplification. Gradually, I introduced more formal reflection, as thematization of recurrent meanings or motifs began to constellate. Finally, I gathered these reflections together, eliminated

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redundancy, and determined a more concise Individual Psychological Structure for each participant.

Since Individual Psychological Structures are limited, in that they reflect only an individual instance of a phenomenon, the final step in the cumulative qualitative process involved developing a General Structure, which then provided comprehension of a great diversity of examples. I found evidence of generality in the Individual Structures and formulated the most essential aspects of this generality: its necessary and sufficient conditions and the parts and structural relations that constituted the phenomenon in general. In this way, a general exposition of the experience of Diabasis House emerged out of the process of collecting and analyzing the data.

Within this general exposition, four major areas of participant interest and emphasis emerged, which I will describe in the following chapter. In doing so, I will return often to the precise words of the participants in order to provide the reader with the actual phenomenological flavor of these experiences. Finally, in the following chapter, I will discuss my results and contextualize them within the discipline of psychology.

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CHAPTER III

RESULTS

Qualitative and archival analysis allowed four major areas of interest and emphasis to emerge from the data generated in this study. These are (a) the treatment approach and history of Diabasis and its meaning for the participants, (b) the nature of psychosis, (c) a critique of the medical model approach to psychosis as compared to its alternative at Diabasis, and (d) a retrospective critique of Diabasis.

Each of these four major areas contains two or more themes that will make up the bulk of the content analysis in this chapter. After introducing the participants, I will begin with the area that generated the largest amount of content from them: the treatment approach and history of Diabasis, and its meaning for and impact on the participants. I will then describe the other three major areas of emphasis and will conclude this chapter by reviewing the supporting evidence I gleaned from the Diabasis archives.

Introduction to the Participants

All of the participants, except for John Perry, were in their mid- to late-40s when I interviewed them; all resided in the San Francisco Bay Area. R. was the only former Diabasis House resident I was able to locate. At the time of the interview, she was a working painter, with a studio space separate from her home, although she was earning much of her income doing legal research.

R. told me that she was 27 in 1978, at the time of her first and only psychotic break. She had completed law school and passed the Bar Exam at the age of 24, but found

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herself increasingly unable to work. She was admitted to Diabasis approximately a year after she began to have transitory symptoms of psychosis. During the year before her admission, she had been seeing a psychiatrist and had taken neuroleptic medication (thorazine, according to her recollection) very briefly. When her psychotic process escalated, her private-practice psychiatrist encouraged her to try Diabasis, because he felt her process could no longer be contained without 24-hour support.

Three participants were former staff members at Diabasis. The one man, A., is a licensed psychologist who is currently director of a large non-profit urban mental health services agency. A. began working at Diabasis in his mid-twenties. He had already completed an M.A. in psychology and used his job at Diabasis to complete internship requirements for his Marriage, Family, and Child Counselor license. He later returned to graduate school for a Ph.D.

Of the two women, B. is currently a writer and community activist. She had worked in a state hospital as a young woman, prior to beginning an M.A. program in clinical psychology. She applied to work at Diabasis in her late 20s, while she was still in graduate school, and was hired as a counselor.

The other woman, J., is currently a licensed Marriage and Family Therapist who works primary with children, adolescents, and families in a public sector out-patient clinic As a young woman, J. worked full-time as a ward clerk in a traditional psychiatric hospital in San Francisco. This experience inspired her to return to college and complete a BA in psychology. After graduating, she applied to Diabasis and was hired as an administrative assistant, but was interested in working with the residents and was

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encouraged to do so. After Diabasis closed, she returned to graduate school for a Masters and earned her license.

My final interview participant was the originator and clinical director of Diabasis: John Weir Perry, MD, a prominent Jungian analyst and author of numerous books. Dr. Perry, who was in his early 50s when Diabasis opened, died in 1998 at the age of 84. Most of our conversations took place in the house he built himself, in a wooded area at the foot of Mount Tamalpais, where he both lived and saw clients; this house was decorated with his large collection of artifacts, many Chinese. Dr. Perry continued to respond to my requests for clarification up until a few weeks before he died.

The Treatment Approach, History, and Meaning of Diabasis

The Diabasis treatment approach, including its development and its meaning for the participants, emerged as the most compelling general area of interest and emphasis in the narratives. In examining the data, I discovered three salient themes. First, John Perry's development of a unique but still Jungian "way" of being with psychotic patients, which evolved through his personal odyssey, was the primary and most necessary factor in both the founding of, and the treatment approach used at, Diabasis. His particular "way" used a Taoist "active receptivity" to engage the archetypes of the collective unconscious as they expressed their powerful drama of affect and image on the stage of the Self, which he identified as the archetype of the Center and the source of *agape* (societal love). Second, because of its unique treatment approach, involvement with Diabasis was a major personal and social experiment, and a deeply meaningful and challenging experience, with

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long-term impact on both residents and staff. Third, the social forces that converged to create, define and sustain Diabasis may have been necessary conditions for its existence.

Diabasis Grew Out of a Uniquely Taoist and Jungian "Way" of "Being With" Psychosis that Evolved Through John Perry's Personal Odyssey

The long personal odyssey of John Perry, founder of Diabasis, emerged as of primary importance in understanding the creation of both the program and the treatment approach. Perry's approach, with its unique visionary, Taoist, and Jungian orientation, shaped Diabasis. Without him, the singular treatment approach used at Diabasis may never have developed and Diabasis would never have come into being. The essential role of Perry's unique "way" of being with psychotic patients emerged as the most central and compelling finding across all the participants.

This "way," as developed by Perry, requires the practitioner to be free from any tendency to recoil in fear and judgment or to pathologize the person in need. Practice of this "way" involves compassion, empathy, and an actual sense of kinship, most often acquired through the practitioner's own experience with visionary or altered states of consciousness. This essentially receptive "way," is, however, far from passive: it actively creates a safe and sacred space for the client's process, while eliciting an increased flow of unconscious content. It invites the expression of both personal and archetypal affects and images.

Intentionally fostered at Diabasis, this "way" of being with psychotic clients emerged as more significant for the development of the unique Diabasis treatment

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approach than Perry's formal theories about psychosis. It overshadowed both his theory of an archetypal Renewal Process, which he formulated by drawing on world mythology to amplify psychotic experience, and his revolutionary non-use of medication. Perry responded to a follow-up question on this finding by confirming that "this way of being with clients is what opens the possibility for their process to emerge. The non-use of medication wasn't the main thing to remember about Diabasis."

Perry's account was rich with material that situates both Diabasis and its founder in a special place in the development of clinical psychology in general and of Jungian analytic psychology in particular. Because of both the span of time (1930s to 1990s) and the stature of those involved, Perry's narrative itself is an important document in the history of psychology.

Perry's narrative clarified that the genesis of Diabasis and its treatment approach dates back to a powerful visionary experience he had prior to his first fateful meeting with Jung. Perry's vocation, initiated through this vision, was confirmed by his first experience with Jung, who stayed at the Perry home for several days in 1936 while visiting the United States. It developed further through Perry's experience as a doctor in China during World War II and his subsequent training as an analyst at the Jung Institute in Zurich, where he had further contact with Jung. These powerful life experiences, in addition to Perry's positive initial experiences with psychiatric patients, finally came together in his synchronistic encounter with a "schizophrenic" woman at McClean Hospital, shortly after his return from Zurich. It was then that his treatment approach, his "way" of working with psychosis, began to coalesce.

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Perry's Visionary Experience. Near the end of the summer of 1934, as a young man of 20, Perry experienced a powerful visionary interlude. Throughout the summer, he had immersed himself in intensive reading of scientific works, in hopes of aligning his religious views with modern scientific knowledge, especially the theory of evolution. He had purposely read from "each discipline, the sequence following the order of creation itself: astronomy and cosmology first, followed by geology as the history of the earth, paleontology as the evolution of life and development of mankind and psychology as the latest phase."

Perry's reading and reflecting culminated in an "intensely moving experience":

> Sitting on a hillside in the late evening, as I frequently have been doing, pondering these questions and looking up into that vast accumulation of suns stretching out over that disk that forms the Milky Way, our galaxy, I'm asking: where's the godhead in all this turbulence? What's the essence of the creative principal in it, the force that drives it all and makes it all happen? Suddenly it comes to me in an up-rush of warm, expansive surprise and a series of welcome insights that seem to well up from inside. The excitement seems to accelerate my thoughts, and ideas come crowding in upon one another, all seeming to answer the questions I've been living with all this while.

Perry found the answer to his questions in the ubiquitous nature of love:

> That which we experience and recognize, on our human level, with our kind of consciousness, as love which we make identical with the divine, must be discernable at other phases of the creative process. What could that have been before there was life, or in the age of dinosaurs? It must be the driving force that, in general, moves through matter to bind particles into atoms, atoms into molecules and these into the tissues of living cells in bodies. There must be a cohesive principle that urges the creative work toward more and more complex forms with higher and higher degrees of organization in the life forms until they culminate in that supreme achievement, our human consciousness. With this, mankind can look into this process and recognize and formulate in his mind the meaning of this wondrous history. However, it does not stop at that: the insights push forward. Surely this evolutionary drive cannot be ceasing here, as if consciousness were not only a pinnacle but also an endpoint.

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An even more intense up welling of insight greeted Perry's realization that consciousness could not be an endpoint and that this "evolutionary drive" must still be pressing forward:

> If the binding of forms together into higher forms is the pattern of the creative process, then the binding of human beings into some higher organism must be what awaits us just ahead. This would be a "social organism," binding separate human consciousness together by the cohesive principle we know as love. This emotion would have to be more than that felt between lovers, partners or friends, something more all embracing; it must be what Christian *agape* was intended to signify. In that case, Paul's vision of the 'Body of Christ," of which we all compose the limbs and organs and become "members one of another," must have been another way of expressing the insight that community becomes an organism when there is sufficient spiritual development. Here at last the traditional religious and the new scientific thinking came together and blended without strain.

Perry was "deeply moved and highly elated with this all embracing vision of the creation and the ongoing evolutionary process." He noted in retrospect that his vision

> had all the features of a "peak experience," i.e., that kind of ecstatic transport which gives an exalted sense of oneness with oneself and with the cosmos....I found my vocation clearly then and there, which was to prepare myself one way or another in psychology to investigate in the psyche the source of the dynamic that generates this species of love, societal love, *agape*, that carries this new thrust of the evolutionary process. It brought a gift of motivating energy that was to persist for many decades to come.

Perry's powerful visionary experience initiated the evolution of his treatment approach. It helped to establish the core meaning of his vocation as a healer and a philosopher, colored every aspect of his work as a psychotherapist, and culminated in his vision's most significant social application: the Diabasis projects. Perry confirmed that "it's what sent me into that whole life quest after. That's why I went into psychology and through medicine."

The content of the vision itself, which was a profound personal affirmation of the sacredness of compassion and human-heartedness, would later be the cornerstone of his

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"way" of being with psychotic clients. In projecting an optimistic future of *agape*, his vision caused the young Perry to feel a great certainty in the rightness of following those values and ideals as his guiding light. They formed a kind of personal, revealed faith in the ability of the psyche to express itself powerfully to seekers of psychological growth and spiritual truth.

The powerful personal impact of Perry's visionary experience, incubated by such intense reflection and seeking, also shows some similarity to what the residents at Diabasis experienced. These young adults were also being gripped by a very unique, archetypal, and unusual subjective psychological experience during their "crisis" or stormy passage into young adulthood. In addition, the content of Perry's vision focused on deep concerns about the nature of love and cultural transformation similar to those of San Francisco's famous counter-culture movement, discussed below as part of the social framework that enabled Diabasis to come into being.

Years later, Perry encountered Teillard De Chardin's revolutionary vision of a future "noosphere" of globe-encircling, evolved spiritual consciousness and noted its similarity to his own vision. He also, through personal contact with Joseph Needham, discovered that Needham too had received a similar vision. Initially, however, Perry had "felt alone with and shy talking about" his vision and kept it secret. He "had no knowledge of any such line of thought [then]....I kept it private until such time as I could do it justice by working it out more fully."

Perry's Experience with Isolation and Rejection. Eventually, Perry attempted to integrate his life shaping vision by having it accepted by another person. The negative

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response of the first person he turned to for understanding left him feeling isolated and rejected. Perry's experience with rejection when he was so vulnerable gave personal meaning to the most recurrent theme in all of his writings on the practical methods of treating psychosis: young adults going through such an upheaval should not be isolated in their unique subjective experience by the fear or misunderstanding of those around them.

Although Perry's vision bears no resemblance to psychotic hallucinations, he was indeed subject to fear and misunderstanding. As he recounted,

> I was longing now to be able to share this experience with some friend. Since that time my preference has been to take my private matters like this to a woman friend to whom I could open myself more easily and fully, but at that time none were companions of this kind of closeness....I thought over how my male friends would react, one by one, wanting to avoid any crushing response, such as "I can't see it that way at all" or "What a dreamer! Where do you get all that baloney!" Finally in my junior year I wrote it all down in one of my red notebooks, and asked W. to take a look and see what he felt. Disaster! I picked unwittingly, with uncanny accuracy, the very one who would say just what I most feared. He was enraged and disgusted and asked me to be sure not ever to bother him with this kind of tripe again! I felt appalled and nonplussed.

Despite not being psychotic, Perry experienced himself as stigmatized in a similar way. His friend had identified him as somehow akin to his (possibly psychotic) father:

> At least [my friend] had the grace to tell me what his repulsion came from—his father was paranoid and spent a lot of his time withdrawn and writing crazy cosmologies, an occupation that held him back from relating to his son. Paranoid fantasies! Dangerous stuff? Though I could see that he had responded more to his father than to me, it did not prevent my feeling dashed, hurt, and much more afraid of revealing my vision to anyone than before. I therefore sat on it for a couple of years more, reading whatever I could find.

Because Perry's experience was so numinous and unusual, it produced a very negative reaction from his young friend. Perry acknowledged that his friend's negative reaction was the initial experience that sensitized him to the need for people having psychotic episodes to be received with empathy and understanding by an "other." Being

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responded to in such a strongly contrasting manner seeded his own "way" of being with psychotic clients. As such, the rejection itself has numinous and synchronistic qualities: he "picked with uncanny accuracy" the one friend who would in fact have the most disastrously opposite reaction to what he needed.

Fateful Encounter with Jung. Perry's new faith in the psyche bore a remarkable similarity to that of Carl Jung, who trusted the psyche to offer up numinous, transcendent direction and inspiration to the seeker. In the very midst of trying to figure out how to articulate and plan the vocation that his vision was prompting, Perry had another uncanny experience: he met Jung.

Some time after his friends' negative reaction, 21-year-old Perry had begun to receive support and counsel from one of his Harvard professors: Henry Murray, the prominent psychologist. Murray had urged him to pursue his vision by way of a vocation in psychiatry and religion and to read Jung's recently released book, *Modern Man in Search of a Soul*: "That I did," Perry recalled, "and was decidedly attracted to it."

Just prior to Perry's receiving his B.A. in Literature and History from Harvard, his father, the presiding Anglican Bishop in the U.S, had been travelling in Europe. The Bishop, seeing his son as something of a gifted dreamer, was concerned about what the future would hold. According to Perry, while in Zurich, his father

> fell into conversation with a Swiss colleague about their sons. When it came to me and my wandering quest, the friend exclaimed, "Why, the man to see is just nearby in Kussnacht! I know him well." So a meeting with Dr. Jung was arranged and these two father figures talked and enjoyed each other. When Father and Mother arrived back in New York I met them, full of expectancy about revealing my plans and apprehensiveness about how it would strike father. After narrating his encounter with Dr. Jung and asking his counsel on my aims, he very gingerly edged up to the punch line, which was that Dr. Jung suggested I might have to

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> think about medicine and psychiatry—this just on the verge of breaking the news to him of my decision and first successful step! We had a good laugh at this neatly choreographed dance: but it felt awesome, too, in this play of coincidence so highly charged with future.

Only a few weeks later, Jung and his wife Emma came to the U.S., so that Jung could receive an honorary degree at the Harvard Tercentenary, and accepted an invitation to stay at the Perry home afterwards. Perry arranged to pick them up at the celebration. He remembered this "heady occasion" as having

> all the feeling of a magical experience marking the beginning point on the road to my career: the signs and turns all seemed to be saying, "Yes, you're going the right way." Since I was to transport Dr. Jung to our home, it had been arranged that I could attend both the grand reception and before that some of the lectures given by these dignitaries, Eddington, Malinowsky and others whose work I knew something of. In the Gardener Palace, a sumptuous Florentine edifice with lofty rooms and famous paintings adorning the walls, gathered a large number of the foremost minds of the day, appearing at the Grand Reception. Though I hardly expected such fortune, I was allowed in to meet with Dr. Jung and I had dressed for it just in case. It was dazzling to behold this large array of the foremost minds of the day, appearing to me like a cluster of bright stars. There were recognizable faces here and there such as Einstein among the stellar personages filling this regal ballroom. I was introduced to one or two, including Pierre Janet, feeling quite like an interloper and gate crasher.

On meeting Jung, Perry was "utterly taken aback," his expectations confounded by Jung's demeanor:

> From his writings I had pictured a Germanic sort of scholar, more at home behind his desk than out in the world. What appeared here was a large, jovial, high-spirited man appearing more like a Swiss villager from the Alps than the profound man of great mind that he was. Obviously a veritable *Mensch* of this kind would not spin off books from the top his head but out of the vitality of his experience. This touched my heart right away.

Jung's outward manner affected Perry, the reserved New Englander and Anglican Bishop's son, quite strongly:

> At Bishop's House, Dr. Jung regaled us with his outpouring of rich thought, including colorful accounts of things he learned both from his work and from his investigations into myth and religion. For two days he hardly stopped talking. A

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> Rhode Island man who had worked with him and written some pieces about his experiences was invited to meet him; the greeting Dr. Jung gave him surprised and delighted me when he gave a whoop and enthusiastic embrace as he would with an old chum. Is this the spirit in which a professional relationship is conducted? I wondered, for I had seen other doctor-patient encounters before and had always noted a decided reserve.

During Jung's stay at Bishop House, Perry had his first experiences with Jung's ability to "uncannily and at times very disconcertingly constellate deep reactions in the psyches of those around him"—an ability Perry also noted later, during social gatherings in Zurich. He remembered that, initially, he was

> deeply attracted to this man's views and experiences, but [I] was still green and found myself reserved in judgment. Could I be sure all this was more than the predilection of a European kind of mind in which scholarship created a sort of world of its own making? Someday I would be in a position to see for myself whether the dreams of patients, and the effects they had, were really like what Dr. Jung was speaking about.
>
> My psyche though, was not so tentative and that night produced a dream that I could bring to the master then and there. In it I was standing by the fireplace in the living room with my hand on the mantelpiece: a Native American warrior, bare-chested, grasped his tomahawk and threw it forcefully directly at my chest. In a startled response I managed to catch it in my hands. I lost no time in bringing this message from the psyche to the master, and got from him a message no less forceful than the tomahawk; "Yes, you see? Your archaic man in your psyche wants your attention!" Score! The echoes from that simple pronouncement reverberated through my psyche for many years after.

In another enriching intimate conversation on the relationship of psychology and religion, Jung told the young Perry that

> it is in fact not the personal heroism of some ideal person of genius who alone forges new ground in this overlapping area, but the archetype of the Wise Old Man, an image whose function in the psyche was to carry out just such synthesizing and integrating of the data of experience for their spiritual relevance....All this, of course, struck home for me in a particularly stirring way, since I had been entertaining ambitions to interrelate extensive studies of psychology and religion in the context of a framework of evolutionary sciences....In time I was to find out that my grand plan was eventually to be redesigned in unexpected ways by the archetypal psyche instead of the intellect.

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Perry remembered yet another interaction that highlights Jung's remarkable intuitive way of "reading," and then having an impact on, a person's deep psychological process. Jung commented that

> when I look into his work he would recommend above all that I read his Chapter Five in Psychological Types. I later learned about such statements of his that they were often not meant merely as his valuation of the piece in general but that they were addressed specifically to the individual and offered as his intuition of what might in time be found most relevant. When I did read that chapter a little later, I was surprised to find how directly it spoke to me. It is an extensive exploration of the dynamics and conflicts of the introverted and extraverted attitudes. The main thesis is that if one or the other predominates too much and for too long a time at the expense of the neglected adaptation to the outer or inner world, the psyche reacts quite spontaneously to correct the imbalance. A back-flow of energy activates the unconscious processes in depth with the intent to establish a new center. A new reconciling symbol is formed to provide the needed balance and synthesis of the opposite attitudes. A rich exploration of this imagery follows, as expressed in terms of various religious and spiritual disciplines, especially Hindu, Buddhist, and Taoist, as well as Christian.

In "prescribing" this chapter for Perry, Jung uncannily prefigured Perry's later (1951) formulation of the Renewal Process, which described psychosis as the most powerful play of imagery and meaning possible in the individual psyche and emphasizes the role of the Self as the "central archetype," where opposites are synthesized. Reading this chapter also guided Perry toward an understanding that

> living in the "service of the soul" in its feminine image is...all too apt to be concretized in the figure of a loved woman, in the experience of an individual male, and in that of a goddess on the collective level, both of which may stifle the psyche's attempt to provide its own viable orientation to and imaging of the soul bearer. I have often gone back to that essay to keep mindfulness about this feminine soul image, a major motif in my emotional life.

Jung had "spoken to" Perry's emotional nature, which was already developing a receptive, feminine orientation. This feminine, receptive style of being with both self and other later grew into Perry's "way" of serving people in the psychotic process.

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Returning to Harvard after Jung's visit, Perry felt confirmed in his plan to pursue medicine. However, still somewhat wary about Jung himself, he retained a "wait and see" attitude. Henry Murray, like a "true friend," forcefully argued against this and convinced Perry to commit himself to a Jungian orientation:

> Hearing my hesitancy he exclaimed, "Wait a minute. Aren't you realizing the gift that's being put in your hand now? You must realize there are countless people who'd give their right arm for a chance to spend even a little time with him, let alone a couple of days! Don't let this slip through your fingers!" Jung, he explained, was not yet being given much acceptance in this country because we were culturally not ready for it and he was way ahead of his time; this might change after perhaps another decade or so.

Perry went on to pursue his medical training and, after his third year in medical school, finally had a chance to work in a psychiatric setting. To his delight, his clinical work with patients during a summer job at Butler State Hospital confirmed Jungian ideas: "There it all was, out in the open, concerns of death and rebirth, regression, religious preoccupations, and mythic ideation. I loved it and found these people fascinating."

Perry's Experiences during World War II. Powerfully influenced by the non-violent activist philosophy and spirituality of Gandhi, which he found consistent with his arresting vision of societal, *agape*-based compassion, Perry became active in the movement to prevent the U.S. from entering World War II. During his medical internship years, he applied for conscientious objector status and was permitted to perform alternative service with the Friends Ambulance Unit. The Friends sent him to China to perform as a battlefield surgeon and to set up and administer numerous field hospitals for the flood of Chinese casualties created by the Japanese invasion.

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Perry's war experiences, which freed him from fear of death and horror, contributed to his ability to stay present with psychotic patients through their most extreme states. His long trip to China involved near-confrontations with the Japanese, during which he realized that his life would be in danger for much of the next few years. He reported that, "ever since that time, I have not feared death, feeling that I had looked it straight in the face and made my peace with it." During the ensuing years, Perry experienced firsthand some of the worst extremes of human suffering: famine in Calcutta, war casualties, epidemics of typhus and cholera. He responded, as he later did when confronted with psychosis, by actively and compassionately working to alleviate this suffering.

The Influence of Chinese Culture. During our interview, I remarked to Perry that many psychiatrists from the U.S. had trained in Zurich, but only he had specialized in working with psychotic patients or written about such work from a Jungian perspective. I asked if his encounter with Chinese culture might have been a variable that led him to relate to psychotic clients in a particularly receptive way. I speculated that other Jungians might not have been able to approximate this receptivity. This may have prevented psychotic clients from opening up to them in the remarkable way they had to Perry

In response, Perry agreed that his experience in China was

> part of it, a very subtle part that's hard to put your finger on....At the time I couldn't put my finger on...what it was. I knew China had had quite an impact on my whole way of being, I think, not just way of thinking. It *did* have to do with the receptive as a big thing...not only Taoist Philosophy, but...in just the ordinary work-a-day life of the people.

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Perry recognized that, in the walled cities and rural culture of China, he had encountered a pre-modern way of being. The Chinese

> handled their lives in a receptive sort of mode, very open to what happens, not trying to make it be something. They were just moving with the circumstances and waiting for the right time for things. The way they treated each other and treated us, again, had the receptive quality. It was sort of an invitation to reveal yourself, to let me know who you are. Let's really talk. Almost never a judgment. In fact judgmental reactions were uncouth and offensive. Honoring what the other person is was almost the chief principle of relationship, that you don't offend, you don't diminish the other person to make him lose face, give him the honor that's due him or her. All that translated into...it impressed me and I loved it. I wanted to go back there again.

Perry also acknowledged the similarity between the way of being practiced as a matter of course by the pre-modern Chinese and the way of being taught by Jung, who himself seemed very Taoist to Perry. He described how what he absorbed in China

> wove itself into the Jungian things that I learned...a year later, where the receptive again operates in the same way. Jung's way of conducting an interview was to find out who this person is you're talking with in a session. He told me one time, "You [may] want to analyze right from the beginning"—I hear the dreams right at the start and get a diagnostic impression from those and delve deep right away. He said, "Don't do it. Get to know the ego and the person who owned it first." He said, "Spend some time just finding out who this person is and then when you run across shadow things and complexes, you have some perspective on what they mean and how they relate to the ego standpoint." That sounded very Chinese to me.

This "very Chinese" way became a crucial aspect of Perry's analytical style, which he then brought to his later encounters with psychosis. He remarked:

> If you open yourself to a question and allow [the patient] to reveal what she actually is, in spite of all this stuff filling the air, tune in on that person and don't get rocked by the disturbance and the kind of awkward, irrational content that keeps coming through, that person senses it right away and opens up right away. If they're approached in a judgmental way, the way psychiatry usually does, they shut up right away, they get defensive and hide.
>
> So yes, China had a direct impact on me mostly in terms of relationship. I was fascinated with the non-rational sort of stuff in Chinese culture, all this symbolism you see all around, the architecture—that was fascinating, but not the essence. The essence is more this thing about nature knowing best. I think the way

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> of nature *is* Tao, it is the way the Chinese lived at that time—it's gone now, but it was then—and the way of nature is the way the psyche works. So, I had already learned that respect for the way of nature before I even got to Zurich.

Perry's Experience in Zurich. After the war, Perry completed a one-year psychiatric residency at McClean Hospital in Boston. Already having embraced a Jungian orientation, he carried into this experience Jung's general framework, which eschews polarization between doctor and patient. Perry noted the contrast between this perspective and the "psychiatric standpoint: 'I'm normal and the patient is crazy.' 'The patient needs me to get normal.' So, there's a squaring off right at the very outset."

Despite difficulty in communicating about his work with the staff at McClean, Perry focused on offering "myself to whatever was wanting to happen in [an individual's] psyche, according to the way of nature." Even more than during his experience before the war at Butler State Hospital, he confirmed for himself that a Jungian approach could help seriously disturbed patients. His work with a deeply depressed woman served as his psychotherapeutic "initiation" or "rite of passage." Because he pleaded that she be spared electroshock, she began to feel hopeful and "her psyche stirred into new activity." Her recovery deeply impressed Perry with "the beauty of the psyche's way of expression and healing."

At the end of his residency year, Perry, at the age of 29, traveled to Zurich on a Rockefeller Fellowship, for a post-residency stint at the just-forming Jung Institute. While the Zurich experience as a whole affected him deeply, two aspects of it particularly helped to shape his "way" of being with psychotic clients. The first was his intense training analysis. On Jung's recommendation, he underwent a very unusual dual analysis with C.A. (Freddy) Meier and Toni Wolff. Perry's psyche responded by becoming

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remarkably active and "explosive," offering him a plethora of intense dreams, whose images he painted almost daily. At one point, he began to wonder

> if all this hyperactivity of the psyche might be going to pitch me into a mental crisis....In this regard, I took the notion of possible psychosis not as pointing to some flaw in my organism, but as an expression signifying the exceptionally forceful psychic eruption....Narrow is the margin between a psychosis and a highly activated psyche releasing its creative potential!

Perry also described his contact with Jung—with whom he met alone, every two weeks, for free ranging discussions on many topics—as deeply influencing his "way" of being with psychotic patients. Perry had no plans to specialize in psychosis. However, he remembered that Jung, in discussing his own attitude towards psychosis,

> made a point that stuck with me. It really impressed me. I didn't know what to make of it at first. He talked about a certain person with paranoid trends who, while not able to be very loving, had a very loving nature that was hidden and inevident [*sic*]. He described suggesting to that person that his loving was waiting there to be freed up, and it would make a great difference to his healing if he could let go of it. I had been indoctrinated that lovingness was simply not in the picture in this kind of make up—withdrawn people that are antisocial, shut-in personalities, that kind of thing. So, I wasn't at all prepared to recognize this potential lovingness that was sort of sitting there below the surface, just waiting to be liberated like that. So, that struck me. I wasn't planning to do anything about it, but it did interest me.

Perry also explicitly cited Jung's own work with psychosis as an influence on his development of the "way:"

> I was always reminded of that delightful story of Jung's being sent this girl from a mountain village by a local doctor—a schizophrenic, a young adolescent I think , 16 or 18 years old,. She arrived and she was all withdrawn and tied up in herself....Jung said, "Well, what kind of thing do you enjoy?" She said, "Well, I like to sing, that's been nice." He said, "Let's do it." So, he invited her to sing a song together with him and then pretty soon they were dancing. She got into it and really started to enjoy it and opened up. Then he talked to her a bit, not much, but she came out of her shell...out of this really awful withdrawn state. So, pretty soon he was sending her back home, after a few days. The local doctor talked with Jung and said, "What did you do to this girl? Nobody ever does that with a schizophrenic! What did you do?" He said, "Well, we sang songs and we danced around the room together and then I just let her go."

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> That's the shaman in you and me, you know. You just do...whatever seemed to be the expression that was needed to open [her] up. She was probably in touch with herself the whole time, but caught in herself....So, that was kind of a dramatic form to express this principle—that openly being together and feeling good with each other and receiving each other in that spirit is the essential healing. The rest is all sort of a substitute that [can] get in the way.

Encounter with the Renewal Process at McClean. Upon his return to the United States, Perry began to work again at McClean Hospital in Boston, this time as a psychiatrist. He described himself as having carried the intense atmosphere of Zurich with him. This, he noted, was a crucial element that allowed the "way" to emerge:

> What made a difference, but more indirectly, was when I came back from Zurich, having gone through quite a deep trip, many, many dreams each night and very colorful and very archetypal ones....You arrive from Zurich in a very strange state. You're only about half in the real world and you're still drifting out half in the psyche. It took me a few months to kind of get grounded again. All of which is not in any sense regarded as negative in any way. It's just a phase you go through in that kind of therapy, where you feel inside out, as if without skin—open. I think the patients I was working with felt that I was wide open to what they were experiencing.

The first patient assigned to Perry at McClean was diagnosed as a catatonic schizophrenic. It was she who initially "opened up this thing of being at the center, which she represented as a mandala, with the opposing world forces putting her in the center." Perry worked closely with the patient, eliciting more material through having her paint the images emerging from her psyche. Eventually, as the opposing forces balanced and "resolved their differences" in the Center, or Self, the patient was clinically considered "in remission."

Perry credits his ability to connect immediately with the patient's material to the aftermath of his Zurich experience:

> [It] struck me right away, and I think, in a way, all that I had been through in Zurich allowed me to hear that, from a particular kind of position....I would have

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> missed if I hadn't been there just recently. It gives you that kind of open communication with the unconscious, going back and forth.

Asked whether he considers it synchronicity that this woman revealed herself at that particular time, Perry responded,

> I do. It just opened up a gateway there that I didn't expect. What I had in mind was to work with psychosomatic imagery and certain psychosomatic disorders. I thought that was a place I could use my medical education, and that I might have a flair for the kind of imagery that would come up in that regard. I talked with Jung about that and was all set for it, even doing some reading about it. Then this thing came out of left field and just gripped me, and I just wanted to know more about it.

Further Evolution of the Treatment Approach. Perry's experience at McClean shifted his interest explicitly to the therapeutic treatment of acute psychosis, with an emphasis on "discovering and exploring the psyche's self-healing capacities in the midst of crises." At the age of 31, Perry moved to the San Francisco Bay Area, where he worked with many acutely psychotic and otherwise "highly activated" patients and helped found the San Francisco Jung Institute. In 1951, he published *The Self in Psychotic Process,* in which he presented the McClean case described above and developed the theoretical aspects of his treatment approach. Jung's forward "authenticated the work." Nevertheless, it disappointed Perry, since Jung never acknowledged "the main thesis of the study, which was that a self-healing process was taking shape even in the midst of psychic turmoil;" Perry believed that this was an original contribution, which went beyond Jung's findings.

In the late 1960s, after many years of teaching and practice, Perry became involved with the research project at Agnews State Hospital, which I discussed in the introduction to this study. His experience at Agnews moved him out of a learning mode and into an action mode. He became thoroughly convinced "that, where nature was

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arranging a reorganization of persons' psyches, our profession was blocking that and, instead, shunting them mainly into a life of chronic disability." This conviction left him feeling deeply distressed over

> the needs of people who get into acute episodes and had not been getting a fair shake. That it really is the humane thing to do, to set up a [program] like this and demonstrate that it can go a quite different way. Before that, it had been more a matter of curiosity—intellectual, psychological curiosity about what this inner process was—and exploring it, but without that sense of urgency about the social need....I really was much more thoughtful about the social need. That was probably one of the most extraverted periods in my life...lobbying in city hall, city agencies, mental health departments.

When Perry met Loren Mosher, who worked on the initial planning process for the Agnews Project, he was able to learn about the approach of R. D. Laing from someone who had first-hand experience with it. Perry described Laing's approach as

> "bring people in, get them the setting, clean out the emotional atmosphere around them." Not much interest to be shown in the content of the inner process. I [in contrast] was absolutely set on getting a staff who could listen to the process and really ride with it. This is what I tried during the Agnews Project, and it didn't really fly very well....very hard to have a hospital staff, who have done things in a medical model way, change their head around and look at it in a different way and drop old habits.

In the course of planning the program that was to become Diabasis, Perry clarified what he believed were the necessary requirements for a practitioner of his "way." He was particularly emphatic that the most effective practitioners would be those "not coached and experienced in psychopathology," since the experienced psychiatric staff at Agnews seemed almost overwhelmingly ruled by negative and pathologizing presuppositions. The most important qualification for a practitioner of this new "way" was, on the contrary, "an allowing, non-intrusive manner, open to unusual states of consciousness." Practitioners also needed to be able to respond with "appropriate nurturance" to regression and have "some acquaintance with inner experience, whether

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through their own therapy or meditation or creative work—perhaps even their own turmoil or episode—so long as it has been quite resolved by the time of undertaking this work."

Since most initial psychotic breaks occur in the young, Perry suspected that being of the same generation and subculture of the clients would enable practitioners to relate to them more easily. He believed that the ideal social environment for practicing the "way" would be a non-hierarchical community—much like the Quaker-oriented community with which he was involved during World War II. He described this as a "beautiful way of life," since it "seems essential that the staff of such a facility meet frequently for the primary purpose of cultivating warm and caring feeling qualities among them."

Perry also clarified the parameters of the physical environment necessary for practice to be optimally effective. The atmosphere of a treatment program employing these principles must be "light, airy, upbeat, suffused with warm feeling [and] as much like a home as possible...completely non-institutional, so that there would be no hint of 'treating mental illness.'"

In retrospect, Perry noted that his work with Diabasis itself clarified another important aspect of the "way." He described how the San Francisco Jung Institute had attacked the use of paraprofessionals at Diabasis:

> It was voiced, "How can you people at Diabasis, with no training, think you can possibly work with the kind of material we work with after going through academic training, medicine, Ph.D., whatever, and then Jungian training for four or five years and analysis? We're more equipped to do this. How do you get a bunch of people who haven't done all we're doing to work with this kind of content?"

Perry stated his response to this objection emphatically:

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> It's not the interpretation that makes it work at all. The process goes on, in depth, in its own way, as long as it has the right setting....the setting has to be part of that open relationship between a couple of people or a group of people, probably especially individual relationships. I think the psyche needs that. The Self, the Center, comes into play when it's happening between two people, and I think *it* does all the work, and I think our part is just to be there in the right spirit. That's why I think a facility like this is able to be effective.
>
> If interpretation were the big thing, if understanding and formulating were the big thing, you would have to have people who were extensively trained and knew all about the symbolism and knew all about archetypes and complexes and all the dynamics and all that; whereas, this way, if you just have people open and loving being there, it seems to have the same effect...a better effect. Jung was likely to talk about it that way too.

Finally, when I asked Perry about the necessary and sufficient conditions for someone undergoing a psychotic process to have a healing experience, he responded quite simply: "It's receiving the process and even before that, receiving the person, I think, in the same spirit. Being in touch in a trustingly open kind of way together. And then the process is free to move the way *it* wants."

Involvement with Diabasis Was a Major Life Experience, with Long Term Impact on Participants

Throughout the interviews, participants emphasized that their experiences at Diabasis both profoundly affected them at the time and have had a major impact on the course of their lives. All referred, directly or indirectly, to the Diabasis "way" as the most important aspect of the experience and all discussed the reasons that brought them to Diabasis. In this section, I will focus specifically on these aspects of the narratives.

R.'s Account of the Meaning and Impact of Her Diabasis Experience. R., who believes that her stay at Diabasis may have saved her from a lifetime of chronic

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schizophrenia, was 27 in 1978, at the time of her first and only psychotic break. She had the credentials to practice as a lawyer but found herself incapable of doing so:

> At 24, I was out of law school and I had passed the California Bar. It had been a very, very directed effort from at least college...probably before college. When I said that I wasn't functioning as a lawyer, I never *functioned* as a lawyer. Obviously, I could do the rote things: get into school and pass the exams and get my credential and such. But, the further I went in that, the more stifled I was and the less I could function...the less I could function, the less I could connect. So that whatever work I did might be praised, but I knew that it came at great cost. But I kept going.
>
> The year prior to my going to Diabasis, I became extremely physically ill. That was literally a physical way of stopping me from working. It wasn't psychosomatic, but it did actually realistically stop me, put me in the hospital.

She had begun to see a psychiatrist "because it was a thing of *having* to. I was very unhappy, very depressed, and very suicidal." She felt fortunate in finding someone whom she could trust: "Although I immediately connected with my therapist, in the sense of feeling instinctively that this was a person who could look at me and help me see what I couldn't see myself, it was [still] very painful."

During this period, she found herself increasingly overwhelmed by frightening dreams:

> When I think back to the time, the primary thing that stands out is really intense fear. Prior to that I had reached a very, very stalled place in my life. Months before I went to Diabasis, I started having a series of very, very scary dreams in which I could no longer make the distinction between the dream and the real. The symbols that were in the dreams spilled over into my real life. I couldn't get beyond the fear.
>
> [My therapist was a] very creative man. He knew that I wanted to make something with the symbols but that I was very afraid. He was also afraid *for* me. At some point he offered me, I don't remember what it was — thorazine or something — just as a way of...relaxing my life. It was getting to the point where I couldn't sleep. But I didn't like [the thorazine] either because it felt like I was just in a twilight state...if I didn't continue taking [it], then the symbols would come back. And I really did want the symbols to come back. I *wanted* the symbols....I wanted to be swallowed up by the images but at the same time I was absolutely terrified of being swallowed up by the images. And the medication just seemed like [something] I could use when I was scared.

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Eventually, after approximately a year of their working together, her psychiatrist referred her to Diabasis:

> After a particular period of a week or so of seemingly increasing frequency of not being able to sleep anymore and being just totally riveted by my own inner world, he called Diabasis and told them, and described a little bit, and they invited me to come for an interview. I remember the sense of the world feeling very, very distant and being...in some receding space of my own, which I couldn't exactly say was my own, because I couldn't really find my space.

R. went through the intake process and decided that Diabasis was what she needed:

> I was already looking for a place like Diabasis. If I hadn't been looking, I would never have gotten to Diabasis, probably. I guess I knew a little bit about [it] from what my therapist had told me, but I don't know that it connected. I knew that I wanted *something*. Anyway, at the end of the interview, they said I could come. Then I got very scared, because when you get what you want...I think I came the next day or the day after that. Whenever they finished the administrative process.

R. cited several aspects of what I have called the "way" as crucial to the positive and healing experience she had at Diabasis. In her interview, she mentioned repeatedly that Diabasis "made me feel free," and that she felt safe in its environment, even though she still suffered from "supercharged fear" at times:

> I couldn't sleep, but I was still very afraid of the night. I would burn candles and that seemed to help somewhat. But then the waking dreams were not fun, because there was no mythic quality to the waking dreams...it was just feeling threatened. For all of the fear, I felt this great need to also keep in touch with these things that were happening inside. I didn't want to lose that. I think that conflict of not wanting to lose the very images that I found very terrifying probably made me a good candidate for Diabasis. If the same thing happened to me now, I don't know if I would be quite as afraid. I hope that I wouldn't be, but, of course, there's no Diabasis now.
>
> I guess I had never been a part of any group...certainly nothing with the kind of warmth that Diabasis offered. Warmth is not exactly right—actually the physical place was very cold because they didn't have any heater. They couldn't afford it, so there were heat problems there. But safety, I guess, [is what] Diabasis offered. The whole experience of being a part of that...in a way I felt very physically safe at Diabasis. Even though the first night I had another scary dream,

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> I had a feeling that dreams were happening *at* Diabasis, too....When I say I was happy there, I *connected* there, I felt *free*, it was just as strong an internal click, an internal connection, that sense of expansion was all through myself....Giving myself, literally, a place—or having been given a place—was very important.

As John Perry, in designing the program, hoped it would, the space itself, especially her room, contributed to her feeling of freedom and safety. It served as a sanctuary and crucible for her as she went through her process:

> The images that go through my mind are of the room I was in...the big room with the fireplace and the big windows and the walls hung with paintings. It was a very full room—I had music and sunlight and paintings on the walls and people that I liked and a fire. I had a whole wealth of images and symbols and it really was great riches. and learning to find that—I think that's what Diabasis was. The finding of that is the most important part. I can just picture myself spending most of my time in my sun-filled room. The fireplace I had in my room, I loved. That was the other thing...just sitting and watching the flames brought me great pleasure, too.

The paintings on the walls were those R. painted herself, encouraged by the Diabasis "way," which facilitated residents' expression of unconscious content. She had painted as a child but had given it up, having absorbed the attitude of those around her that "the inner world isn't important." She cited her painting as a central aspect of her process at Diabasis and described

> discovering that there were certain times in which doing a painting, and translating what I was feeling, was a way...of sort of teetering between the fear and the desire for the same thing. I'm saying this now in looking back at it, but it was more of a feeling sense and kind of a slow discovery sense...in the sense of really discovering a symbolic language. There was certainly some aesthetic pleasure in the doing of it...the messiness — these were watercolors. But more the sense of the language of it and the expansion. It was seizing a part of myself in a visual language, with visual meanings, and that was an enormous release.
>
> The actual paintings...I don't know that they would be beautiful to anyone but myself. The staff people liked them because they could see: "Look at this woman! She's painting up a storm!" It meant things to me and it meant things to people who knew what was going on in my process. And if you put them together as they were in that room, there was a very recognizable progress or progression. They were symbols of things—not like self-portraits in the sense of realistic nose, eyes, mouth, things...they were colors and forms and sometimes circular mandala sort of things.

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In addition to painting, R. described music as "another thing that I had to discover" at Diabasis:

> The other night Brahms' Second Piano Concerto came on the radio, and I specifically associate that with Diabasis because it was a piece I had first heard at Diabasis, and I just loved it. The particular way that it builds and builds and builds and then you think it's over and it just goes to a whole other dimension. It's just astounding to me. So, I must have played that—there were still records in the '70s!—hundreds of times...thousands of times. That's what I mostly did at Diabasis...paint and listen to music.

In addition to the space itself, R. cited her relationships with staff people as crucial to the healing she experienced at Diabasis. She indicated that the most memorable connections she had with people at Diabasis were with the staff: "I've stayed in contact with some of them. I felt a very strong connection with the people that I liked."

R. specifically discussed her relationships with her two "primary therapists," Mark and Lynn. Lynn, the therapist who worked most often with painting,

> had a particular fragrance about her of enormous nurturance and focus...a perfume. It was [her] warmth exuding from her pores. But Mark presented a very brash exterior—someone with a lot of courage and moxie. I thought that was a really good pair [for me]. With Mark it was less of an easy connection, but I still felt very strongly connected. It was different because he was male—there was that element which was different. I think because of my immediate love for Lynn that he felt excluded at times, although I loved him, too, but in a different kind of way.
>
> But also [I knew he would push]..."pushing" is not the right word, but he was very direct and he would want to work on things and so would I, but he would be more likely to *suggest* working on something....My [psychiatrist] might be more conservative in terms of forcing an issue. Mark would—I don't know, it was more of his personality that I liked a lot.

R. described her relationships with Diabasis staff, particularly with her "primaries," as opening a window onto another, more attractive world:

> It was also kind of dazzling. I had never met anyone like any of these people. Everyone I met at Diabasis was unique....I had never talked about my life—about my inner world—and Lynn was offering the fantasy of creativity, and Mark was

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> offering, "Let's go! Let's think about it!" I liked that, too, but I was also a little intimidated by that—I don't know if "intimidated" is the word.
>
> All of the staff shared things about themselves. There were some people that I didn't know anything about except for the way they functioned at Diabasis and I had to make up my own stories about them. But Mark talked about being in an ashram and I didn't even know what an ashram was—it had nothing to do with my background. He was just as stunned that I didn't know what an ashram was, as I was to meet someone who had *been* in an ashram. So, he was presenting me with another way of life, too, a *created* life. A Mark life and a Lynn life—to some extent...Diabasis offered *that*.

R. also described being impressed by other staff people, particularly as they offered models for ways of life that seemed more viable than the way of life in which she had been "stalled." She explicitly mentioned internalizing these models as central to her healing:

> There was a woman named Sinder...I don't think she was anyone's primary while I was there, but what she mostly did was cook. She was very interested in macrobiotics and she could talk for a long time about the yin and yang of foods and, except for conversations about food, and seeing her cooking or smelling brown rice cooking and knowing that Sinder was in the house, I don't know anything about her. She was very calm, serene. I would see her sort of meditating, waiting for the rice to cook, or maybe reading, but I never really talked to her. Whatever she was doing there was what she was doing there. It was another way of being...whatever Sinder had created.
>
> And Dwight, who did the grocery shopping and who was a runner, a very serious runner, a marathon sort of runner. He would sometimes come in in his running clothes. So there was by no means a homogeneity of types of people. I think the only thing that held people together was this commitment to the internal world as having great value....I did learn a lot by being with all the different staff people. I did take in different parts of different people, or understand different things, maybe not altogether rationally. I think it was a recognition of the [internal] process in general, and then how it functions for me, and that it exists in Sinder and Lynn and Mark and Dwight, and all of the other people, in unique ways. Some of this probably took a long old time to evolve in my mind, but they were specific models. I have very specific pictures of these people. It was a very extraordinary place.

R. also emphasized repeatedly that John Perry himself was a powerful and healing presence during her stay at Diabasis:

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> I guess the first time I met him, he just came down, that first week, and...he just said, "Hi, how are you doing?" I knew he wanted to hug me and I don't even know if I let him hug me. I didn't know then who this man was, but I liked him....Yes, he was a very strong presence and that's the only time we would see him, that one evening [a week]....He would come down and you could smell the pipe smoke in his tweed jacket....He would give us all these big hugs and ask how we were doing, or say, "You know, I hear you're painting," or, to one of the other residents, "I'd like to hear your guitar music," or some connection with each of the residents. It was just his very presence. He just radiated this concern and compassion and warmth and interest...
>
> ...When I think of it now, he was like a mythic figure in and of himself, that would come in and touch all of us....I think it was very good "medicine." I think he was giving us each a "dose," but not medicinally. My feeling when he came downstairs was that he really cared, but he didn't want to intrude on us either. I think he was probably also conscious of being the god/king of the house, in a sense, and not really wanting that role. He probably tried to figure out what a good balance would be, too.

When I asked her, specifically, how she experienced the method of treatment, R. mirrored John Perry's description of the "way" as "natural" by saying,

> I don't know that there *was* a method of treatment....I think that...the commitment to the internal world as having great value...[was] the heart of it, and clearly there were some people there, staff as well as residents, who could touch on that and make something of it....For [one resident] who was in utter chaos, it was enough that she could reach some stage of being calm initially. For me, there was some way to translate it, actually, as well as move forward. I think everyone had their own need for what exactly they were doing there and what exactly could come of it or did come of it or would come of it. But, having people there who valued that and who must have come to terms with something within themselves, in connecting with those parts of themselves...it did provide a model of some kind. Maybe that's what John [Perry] did when he came down every Wednesday or Tuesday night. It gave me courage, too.

R. expanded on her sense of the "treatment program" by describing the Diabasis "dictionary," which contained a statement of purpose:

> They had [a definition of] Diabasis as "helping over." Did you ever see that pretty design they had, a Greek statue or something like a Greek image—I don't know if it's a woman—holding the arm of someone else who's like over something? It was very much like that...for me, anyway. Even in the midst of all of the fear, the quality of the dreams that I described, I knew that there was something in those dreams. It was a matter of surviving long enough to see to the other side and surviving in a way that I could have other dreams. [At Diabasis] I

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> could look at parts of the dreams that were scaring me too much to look at them [by] myself. It was that the internal world matters, not only matters, but there is something there that matters, and that you know it yourself, otherwise you wouldn't be there. And we'll help you find out, or help you with it, through it, to the other side.

R. described her memories of Diabasis as even more "enhanced" because it no longer exists:

> It feels like it, too, was a dream, in the sense of it having been closed off...in the sense that a dream is not just open-ended. But that seems to even enhance the power of the memories of Diabasis. It was a very positive experience. For all the little things I mentioned...I liked being there, and I learned a great deal...I learned a lot about processing things. I don't think I knew about that before...

Over a period of weeks, R. began to notice a shift in her process. While it was quite "intense" when she first entered Diabasis, once she began to focus on painting, listening to music, and interacting with her primaries, she began to enjoy herself. However, she also had "periodic times in which the fear would still overcome me...mostly at night. [But] it became less intense in the sense of less frightening..."

During this period, she felt particularly happy that all residents were allowed to stay for three months:

> The woman that was there when I was first there...kept a calendar and she would tell me, "You only have [x] number of days left." I used to really hate that. I didn't want to be tapped in to time and circumstance and things like that....I was a little afraid that they would say, "OK, now you're fine and you have to go. Now you're no longer scared, you have to go." But they really gave you a good period of time to make something of whatever it is you brought.

At the end of her three-month stay at Diabasis, R. returned to living on her own, while continuing to spend time in the Diabasis day treatment program:

> [My process] was less intense [but] it was hard being on my own again. I've always lived alone. I still live alone and it's very productive for getting in touch with one's own self, but at the same time, I remember the first night I was home. It was scary. So, it never rose to the same . . . it wasn't an even progression. It was less intense, but there were still — I never even knew the word "process"

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> before Diabasis — it was definitely a process that was still evolving in its own fits and starts, and within that there were levels of intensity. But it was not the same supercharged fear.
>
> I don't remember the specifics of [the outpatient program] so much. I think it was a specific period of weeks in which you could come back every day, and then a specific number of weeks in which you just continued to meet with the primary people, maybe upstairs or someplace. It must have been during that period of time that I learned Diabasis was going to close. Maybe it did close, and I continued to meet with Lynn and Mark for awhile on the outside. I had [also] continued, during all of this time, with my own therapist. It was, as far as I can remember, a little scary being back in the world.

In response to my question about her life since Diabasis, R. described three distinct periods. During the first, she was able to collect disability as a result of both her physical illness and her psychiatric history. She continued to see her therapist, while working her way through what she described as "my own university":

> reading really widely, buying new art materials and trying them, listening to lots of different music. It was a really wonderful time, but I was very isolated. It was like Diabasis opened a crack to a very wider world and so I demolished the library shelves. Really, it was a very useful time. I was still painting — painting was of more and more importance and the paintings had become the means for me to communicate what was happening internally.

After several years, for what she described as "a variety of, again, internally decided reasons," she decided to return to work, but

> not as a lawyer. I got a job as a picture framer. It was weird, both to be working and...I had never worked as anything other than a lawyer or a law clerk or a legal secretary. It was bizarre, in the sense that it felt like creating another role. But it was a good entry into the world, because not a lot was required of me, or what was required of me was a lot less than I was willing to give. Eventually, I got good at that, and got a good job, and worked at that for seven or eight years. And, again, I continued painting.

The most recent period, which began after she turned 40, was precipitated by her decision to rent an artist's studio:

> That was the biggest milestone of my life—after Diabasis, I should say—because that also gave me a space, a physical space. I have a very beautiful studio and, [as with Diabasis], it was love at first sight. I thought only artists could have studios

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> and, at the time, although painting was central to my life, I didn't know what you had to do to become an artist, and so I didn't think I could have a studio.
>
> I went to look at a shared space and was shown this and it was very much the image of what I thought a studio should be, and what I wanted one to be, and so I took it. Having that space made me an artist—it's evolved slowly but, being defined that way, in terms of having a space in an artists' complex, with lots of artists who are slowly getting works in shows and things like that—it's evolved over the last five years.

During the ensuing period, many things in her life changed. She stopped seeing her therapist on a regular basis and decided she wanted to live less marginally and earn more income. Almost immediately, a former employer offered her work doing legal research:

> I refused, because I've had nothing to do with the law since then. I don't care about it in the least, I haven't kept up or read anything, and I deliberately had my name erased from every directory there is to be erased from. But he kept telling me we could do it as an experiment and, if I didn't like it, I could quit immediately.

Although she resisted for a long time, eventually she took the work and has continued at it. She explained her long resistance as, in part, rooted in a fear of resuscitating the "self" that existed prior to Diabasis:

> It's one of those things that connects back to the past and brings threads forward again. When I first started working for him, it was very scary, because it was like a shadow of me was still hovering around. Each event like that seems to bring all of the things before Diabasis back into focus and sort of tempts the mind. But I could feel it more as a shadow than as a specific threat.

During this period, two other major events occurred: her parents died and she received a sizable insurance settlement, which enabled her, eventually, to travel to Paris. In Paris, she found a fourth "magical place" to add to the magical places she has experienced in her life: her inner world as a child, her studio, and Diabasis.

R. repeatedly expressed concern and regret that programs such as Diabasis no longer exist:

> [My experience was] more than could be dealt with simply by seeing a psychiatrist once a week, and it was something more than *I* could deal with. I

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> didn't have the skills to be a painter then. Maybe, if I had the same overwhelming dreams now, I could immerse myself in my studio and see what happened. But I don't know if I could do that, not having Diabasis. Without going backwards. At the time, I didn't have the skills and enough knowledge about anything to help myself, or even to know what to do or how to do it. So, I needed help, I knew I needed very specific help. Diabasis' recognition of the internal world, and its whole creation of presenting this world, was a miracle for me. I can't think of any other place...books are like that, if you look in the right one. But places and people...
>
> Yeah, it makes me sad to think that there is no place like that. I'm trying to scan my mind, thinking "If you feel that way now, what can you do about it?" Maybe you can connect with someone who went through Diabasis"....But the fact that there is no *place*—no refuge. Because that's what Diabasis really was. I think we should have little refuges on all the mountain tops for people to go to....It *does* matter. And for some of us it maybe matters more than for others. But it matters, and I'm glad to have had the opportunity to have been there when it did exist. I feel very fortunate to have been in Diabasis.

Staff Accounts of the Meaning and Impact of Their Diabasis Experience. After a short period at Diabasis, R. came to the realization that, as she put it, the staff "didn't function just for me or for [the other residents]...they were there for themselves [too]." Statements from the staff, including John Perry, confirm this impression. Perry also confirmed R.'s impression that he influenced the atmosphere of Diabasis. Rather than serving primarily as a source of expert clinical opinion, Perry stated that he found himself

> providing some more subtle form of general feeling or energy, as a kind of presence or viewpoint, that I was told was operating as a source of the atmosphere of the whole. There was a lot of love pervading the entire community that accounted for the healing that went on.

With the exception of John Perry, all of the staff members I interviewed were in their 20s when they became involved in Diabasis and they view it as having had a profound influence on the direction of their lives. J., who is now a practicing psychotherapist, was originally hired as assistant to the Diabasis program director. She had been working at Langley Porter, full time, as a secretary-ward clerk. She related that

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> working there led me to go back and get my psychology bachelor's because I saw that most of the people there were unable to relate to the patients, and how limited the medical model was, and the psych residents were, in terms of life exposure....Before I had entered the job market, I had been very much interested in reading psychology [and] I had gone [to Langley Porter] because I had always worked as a secretary or clerk or a typist, and I wanted an interesting job. I stayed there while I went and got my bachelor's in psychology [and] it was just an eye opener. So, when I heard [about Diabasis]—and I can't remember who told me, but a couple of the psychiatrists who had gone through Langley Porter were affiliated—[they] said, "Well, why don't you go apply?" I had just finished my bachelor's and I needed a full time job and I just went in and applied. I kind of knew what I was getting into because I was up with all the reading and stuff.

In a more typical program, J. might never have had the experiences that led her to become a therapist. However, she was "involved in everything" because of the Diabasis emphasis on non-hierarchical structure. Her first experience with what she called a "journey" with an acutely psychotic man happened while the Diabasis facility was still under renovation and the program was only offering day treatment. She stated that this patient might have

> been my most powerful experience [and] had the most impact on me because I really discovered a part of myself that I didn't know was in there. When you've spent eight hours with an acutely psychotic person—you can't think. You have to operate from your gut. It's hard to describe, it's like kind of an inner strength. In the midst of this chaos, you experience this part that is centered, and you can relate to this other human being's pain on a real deep level.
>
> There were also a couple of times of total honesty. At one point, he was really delusional and talking about cutting off his penis, and he was going to do all these things, and I held his hand throughout the whole talk, and at one point, just like a gut response, I said, "You're really scaring me when you talk that way." He said, "Oh, I'm sorry." He would just clear up, because it was...relating at a level where, I think, you're not...using your head, but yet you're relating on a very real level, for lack of a better word, so that when you actually make the intervention (which you don't even know is an intervention at the time), it offers some kind of relief for that person. Like [a later experience of] cradling one of the residents in my arms and giving her a big hug...something where it just comes by intuition. Or like one guy said he was on fire, so I just put water on him. Things like that, where you spontaneously respond from a place that works.

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Later, J. learned from the psychiatrist in charge of the case that the patient with whom she had her initial experience had singled her out because

> I was nice to this man when his father brought him in the day after Christmas. The psychiatrist took the father upstairs and left me alone with this guy and I was naive and I didn't know, so I just offered him a cup of coffee and I was nice to him. Apparently, at that point I became part of his delusional system, and he wanted to create the Holy Child with me. He had wanted to create the Holy Child on Christmas and he couldn't.
>
> Diabasis felt that once someone made a connection, then you just stayed with that person. So, here I was...the administrative assistant! The staff didn't come in until later that day because it was the day after a holiday and, by that time, he had already made me part of his delusional system.

Unfortunately, because the program was not yet residential, J. was "never able to go through the process with him." Instead,

> we actually ended up going across the Bay Bridge with this guy in a car to hospitalize him at the end....I remember my shrink telling me, "You're crazy, you were with a paranoid schizophrenic in a car crossing the Bay Bridge and just your hand was grounding him!" And I said, "Well, at the time it seemed like a good idea."

Once Diabasis became a residential program, J. was offered a counselor position. She said,

> "No, forget it. I'll just stay in the role that I'm in, and I can sort of have an option of whether I want to spend the night or whatever." But it was kind of loose. Sometimes I would spend the night and sometimes I would stay for dinner. Everybody was in the mix—all the staff meetings just had to do with relationships and trust and that kind of stuff. It had little to do with the running of the place.

J. felt that the non-hierarchical and supportive staff relationships were crucial to the Diabasis treatment model. She noted that

> it really was necessary, just from my experience there, to really feel a sense of togetherness and emotional support. It was a real vulnerable kind of a situation where someone would just go off, and there were several instances where I really had to feel that the people were standing behind me. If I was the recipient of the projection, then I had to know that the people behind me were going to be real supportive, and I think it had a lot to do with the leadership. Basically, John [Perry] and Howard [Levene] kind of were there, and they did any kind of training

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> and everything, but it was basically people who were there on staff that needed to feel that sense. So, [John and Howard] didn't hang out all the time, but I think they created an atmosphere to have that kind of trust level.

J. described another situation, where she was able to go through the process with a client, after Diabasis became a residence:

> What was most striking to me, with those people that were acutely psychotic, when Diabasis was a residence, was when they came out of their process. For a week this man was in his room, had broken out all his windows—there was plastic over the windows—he was nude, and people would go down there and stay with him. He was really psychotic. I would walk in his room and it was really cold, and you would feel like it was a scene from "The Exorcist." Stuff had been thrown through windows, and it would smell in there because he had been living in this acute psychotic space for like a week or something.
>
> There were also a few intense interactions with him where made me out to be Quan Yin, the Chinese goddess. He was doing all this weird stuff, all these gestures that I was Quan Yin. That's when I really felt the sense of the people behind me, and trust. I could feel at ease enough with the psychosis, because I knew they were there. I knew at that particular time that all these people would intervene. So then they were behind me and backed me up....Then one day I came in and he was cleared up and he remembered a lot of it.

J. noted that the program director was crucial in creating and maintaining the Diabasis atmosphere:

> She was young. Her role, I felt, was very important, because she really needed to maintain a real steady kind of a presence and take care of the administrative things in the house, but she also was a person who didn't look at things in a hierarchical way—that she was the boss. She included me in various things and actually encouraged me to go back and get a master's. She provided that kind of leadership.

Unlike J., B. was studying to be a psychotherapist and was hired as a counselor:

> I had worked at Philadelphia State Hospital, back east, which was the hospital that the book *The Snake Pit* was written about, and that was my introduction to mental health care! It was a profound experience; I was there for a couple of years. One of the people who I met during that time was Ross Speck, who was a colleague of Laing, so I really got quite interested [in Laing's work].
>
> I'm not sure exactly how I heard about [Diabasis]. I guess in 1977, my marriage had just recently broken up, and also my daughter was just about three years old. I was doing a master's degree in clinical psychology at Lone Mountain College in the external degree program. I suppose [I was planning to be a psychotherapist while I was in graduate school]....I know I didn't have the

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concept of a career path yet. We felt like we were writing the script for a new world.

B. described powerful experiences working with clients at Diabasis:

I went through one process with a woman—probably one of the most chaotic people who came through Diabasis and I was the primary therapist—being down on all fours on the floor, side-to-side, moving along with her, because it seemed to be the only way to be *with* her. I was really clear that it would be a good thing for her to have somebody with her on this trip, and that was how to do it. I [also] remember very clearly one night following a woman who was really in a very agitated state, who wanted to get out of the house. Now, Diabasis was on Pine Street, sort of between Nob Hill and the Tenderloin. At 4-o'clock in the morning we were wandering around the streets, and I thought to myself, "*She* is crazy! What is *my* excuse? What am I doing here?" There were some very bizarre things done, but I was ready.

There were a number of suicides.[1] I guess for some reason that is one of the things that stands out in my mind. And there is a person who I am still in touch with who, through her experience at Diabasis, was able to really change her life and who has become an artist. She really has a focus in her life now.

One client, with whom B. continued working after Diabasis closed,

gave me a sense of what truly non-judgmental therapy was about. He'd been blocked for years, about committing to a religious sect that he was rather enthralled by. The outcome of the therapy was that he was able to make that commitment. Go figure! I was glad for him. It certainly was what he had been struggling with. It allowed me to have a good opinion of my ability to be non-judgmental.

For B., Diabasis was an integral part of an intense period in her life:

Most of us who worked there...were absorbent sorts of creatures. I loved writing the poetry that came out of it. I guess it was totally absorbing, totally absorbing. I didn't feel as though I was in a state of pretense, ever. The reality of the experience was immediate, all the time, and [that] was across-the-board in my life, as well—work, family, love, writing, everything was in my face. So, if you go for that sort of thing, it was very real.

The third staff member I interviewed, A., had already completed a graduate program in psychology and came to Diabasis as an intern:

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[1] According to John Perry (personal communication, January 20, 1998), there were only two suicides in the history of Diabasis and both happened after the clients had left the program. My review of the archives supports his contention.

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Obviously, I was much younger then than I am today, and I had only had limited exposure to any type of psychotic patient. I was in my mid-twenties and had a master's degree. For the most part, I had worked with non-psychotic patients, so I didn't know how to make a real comparison, anyway. I think I went to a conference somewhere, where there was a booth, with some representatives from Diabasis. I heard a little bit about it while I was in graduate school and was interested to know that they had some internship positions available.

I was interested in the concept of working with clients in an alternative setting, particularly, at that time, without the use of medications. So, it was just a fascinating experience, to be thrust into the middle of this milieu, where there were very, very unique behaviors going on which were, if not encouraged, certainly tolerated, given space to manifest. There was a very strong culture amongst all the staff to not try to dampen the psychotic process while it was happening.

A. described his most memorable experience with a Diabasis client:

Unfortunately, [it] worked out horribly. To cut to the chase, this was a person who, although seemingly doing well at Diabasis, killed herself a few months after she left us. That was a very painful experience; it was one of my first clients, and...I was not by any means a very good therapist at that point. She developed a very strong attachment, transference, or whatever more fancy word you may have, to me during her psychotic episode. The supervisors felt this was a good opportunity to try to take somebody through the experience.

She was, of course, very attached to me and it was a very tough experience, to continually set boundaries, which I did, and I learned a lot from it. In a funny way, it was a very helpful experience in terms of setting boundaries. If anything, it may have set a course for me for the rest of my therapeutic career. Hopefully, not rigid boundaries, but very well-articulated boundaries, just because she compelled the other to do that, since she was totally incapable of doing it. She would literally send out invitations to our wedding, to my family.

This resident had changed considerably by the time she left Diabasis:

She certainly "came down," if you will, from the experience, and was not actively psychotic by any means....She was somewhat depressed when she left, as opposed to days and days of sleeplessness and all the other behavior that she had. And then she left, and then we a got word from her sister a few months later that she had moved to Canada and killed herself. So, that was a very early case that I was involved in, in which someone pushed me very hard as a therapist.

Fortunately, A. has memories of more successful resolutions as well:

There was one client who just flipped out—she took off all her clothes, and she was running all over Pine and Bush at 5:00 in the morning, either with or without a blanket, nothing else. I seem to remember she liked to do that, about two or three

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> times. My memory is that she is one of the people who got her act together and benefited from it.

A. also emphasized that Diabasis staff received excellent training:

> I think that that Jungian perspective prevailed amongst most but not all of the staff. I had a little bit of that, I had read a little bit of Jungian stuff in graduate school, but by no means was I an expert on it. That was one of the most enjoyable parts about it, the Jungian perspective of the place. Both Perry and Peter Rutter, who was the other psychiatrist there most of the time, they really used that—that's how they were trained. I found that to be very helpful frame for understanding what was going on with the clients there.
>
> For me, that intellectual aspect of it was also one of the most enjoyable parts. I did a lot of reading. Peter Rutter had a regular weekly training session that several of us attended, trying to put it all in the context of Jung's writings. That was certainly intellectually very helpful....The development of the therapists was probably what Diabasis was potentially better about even than treatment. I would like to think that people came there for the services were served by it, but I don't know much about its success rate. But I certainly know that several people got good training as a result of it.

John Perry commented that, while he was repeatedly drawn back to doing this work, it might need to be done primarily by therapists in the early years of their careers. All staff participants emphasized their youth at the time that they worked at Diabasis and either implied or explicitly stated that they would no longer be able to work with un-medicated psychosis. A. said,

> If you don't know that you're doing anything wrong, or if you assume what you are doing is right, or you don't have any other reason to judge it negatively, what you are doing is just a fascinating experience. So we were buoyed by a certain naivete. No one was really telling us that what we were doing was wrong, so we weren't very defensive about it. It just made a lot of sense, and made for a very exciting place to work.

B. emphasized that "at one point in my life I could be with it. I could be right along side. It amazes me that I was able to do that, and I am grateful that I was able to do, but I can't do it now." J., reflecting on the same issue, remarked,

> Of course, I was a lot younger then...I was young, the staff was young. I don't know if I would feel the same now. It was such a different kind of experience then.

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> I don't know if I could work that way again...Now maybe I have too much information. I hadn't gone to graduate school....It was from that level before you become a professional and I think its effectiveness [came from using] paraprofessionals.

Despite reflecting on their youth at the time, staff participants also emphasized that Diabasis had a profound and long-term effect on their sense of reality. B. remarked:

> I think it just made me really aware of the subjectivity of experience. I mean, I know what this blue looks like to me, but I don't know what it looks like to you. I know that you and I can both agree on calling it blue, but I don't know what it looks like to you. I guess that gives me a certain compassion, even for people like Ronald Reagan. You just have to assume that reality is something different. When I can stay patient with that, it keeps me more humble than making assumptions.

J. put her changed sense of reality in the context of a story:

> One day I walked in and—I don't know if you remember Grace Slick's song "White Rabbit"—I walked in and the residents were having a dance. Then I went upstairs where the staff is around the dining room table and I said, "You know, I think I saw a white rabbit. Did I see that or not?" "Yeah, so and so brought it last night." I said, "Oh, OK." Because the reality was so different, it was like a different zone. Then I remember times when...I would leave and I would catch the bus home. I would look around and [try to] make eye contact, but no one made contact, so I closed off. And I thought, "What's more crazy, this or what was happening back at Diabasis?" What was happening back at Diabasis, I remember it felt so real. What seemed unreal was really what was happening on the bus, where no one wants to relate to anybody and everybody's closed off or scared. So, I felt like my reality was getting affected a lot in that way.

All three staff participants described Diabasis as having a long-term impact on the work they do and their attitude to it. J., who still practices as a psychotherapist, primarily with children and adolescents, said that the part of her she discovered at Diabasis:

> really helps me and really prepared me to work with kids, because [psychosis] is just a childhood place. They're regressed to the point of that earlier...time that Perry talks about, the root of psychosis....Having had the Diabasis experience [also] helped me in working with teenagers, because it taught me to tolerate high levels of anxiety and intense transference.

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B. is now a writer who specializes in Eastern European politics. She described how her experience at Diabasis influenced the direction taken by her life:

> There were so many pieces that went into creating Diabasis. One major piece of it was that I think one person's madness really had meaning for others of us. If you think about madness in systems [theory] terms...that was part of what Diabasis was about. Then I was very interested in personal experiences [of madness, but] I have gotten to be more interested in the social manifestations.
>
> In the early '80s, at the beginning Reagan's presidency, along with other people, I started getting nervous about who was minding the store. It seemed to me that there was a collective psychosis. If one element of psychosis is fragmented thinking—this reality does not impinge on this reality—collectively we share something with that. I can see that people who really wanted to leave their "good life" to their grandchildren were not paying attention to the fact that they were also participating in undermining the air, the water, and the possibility of a nuclear-free future. The realities did not impinge on each other, and I thought, "Wow, that is just like psychosis." Here we all are in it together, and nobody is correcting the perceptions.

B. became involved with presenting workshops, created by a systems theorist and internationally known social activist, which explored emotional reactions to political issues:

> It was certainly earnest. It had that in common with Diabasis. It was a way of seeing and a way of understanding that madness was not just an individual experience, but a collective experience as well. Somehow, increasing consciousness seemed like a useful way to approach what the problems were. So that was my next step, and since then I have been interested in a general way in how people live in the larger social setting.

B. saw a major correlation between the work she does in thinking about political ideology—how that influences, allows for, or does not allow for, deviant behavior—and the way we view and respond to psychosis. She felt that John Perry's theory and "way" had a direct impact on her ability to take on this work:

> John's picture is an incredibly optimistic picture because it sees the potential for growth, the potential for health and clarity, or order, out of the most primitive chaos. After my own sense of complete despair—I personally thought that the world was coming to an end, I all but made up a sandwich sign: "The end is near," that was me—I seem to have found my way through that to a sense of real

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> possibility of renewal. Which is probably why I got so taken with the events in Eastern Europe. Talk about coming through and reconstructing out of chaos....I guess the underlying message at Diabasis really does very deeply form the way I live and see the world.

A., who now manages a large mental health services agency, also described Diabasis as having a direct and major impact on his work. He felt particularly influenced by what I have described as an integral component of the "way" developed by John Perry: faith in the nature of the psyche. He said that he learned at Diabasis,

> not to put any artificial boundaries around clients. The whole concept of not using medications, but honoring the process, has affected me in every way imaginable. To assume that it wasn't just an illness that was out of control, but that, in fact, it was an attempt for expression on the part of the individual. In the best sense of the word, I think it was a very humane approach. It assumes that the person who is there with a problem is also trying to solve that problem, maybe not correctly, maybe with great difficulty, maybe inarticulately, maybe in a way that is actually harmful to themselves as well. But, at least that there is an attempt for restoration and healing at the same time....So that concept, that people are always attempting, on some level, to correct the things that are wrong, I think is a very important concept for therapists to have.

A. noted that, even though he no longer practices psychotherapy, the Diabasis "way"

> clearly is the basis of how I approach [my work], even though the people that come to us are homeless, disabled, or have a whole string of issues that they are struggling with unsuccessfully. Without being Polyannaesque, I still think the basis of the work has to be that you've got a potential partner in the person you're working with, in terms of knowing what the answers are and in trying to find some solutions to what's troubling them. So, that is a very powerful teaching, very un-medical-minded. It does not presume somebody knows better than the other person, and it does not presume that there is a force over which somebody is totally powerless. It does not assume that all the behavior, at base, is evil...but it realizes that there is always a certain element of healthiness that you can see in the maladaptive behavior.

A. emphasized that the Diabasis perspective has wider implications, as well:

> [My current agency] works in a very poor community, with young adults, in their late teens, who society has given up on because "all they want to do is gang bang, listen to gangsta rap, blah, blah, blah." The simplistic answer is: "They have made

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> bad decisions, they're just bad people, give up on them." Or build walls against them. But as scary as people are, the message from Diabasis is, on one hand, that this is to some extent just an unincorporated part of all of us that seeks expression. And, two, in a funny way, that the rebellion that is being expressed is still life—the kids haven't given up. It would probably be worse if there weren't any energy coming out at all. At least there's still some expression of life, trying to accomplish something.
>
> Yes, it is dangerous. Yes, it is maladaptive. Yes, it should not be tolerated, that people should be expected to be at risk from other people. But that [destructive behavior] is more just a specific expression [of the life force], rather than the life force itself. So again, it's trying to figure out if, using the Diabasis model, a safer context can be created, where nobody's getting hurt.

Social Forces Converged to Create, Define, and Sustain Diabasis

The participants in this study repeatedly cited certain "forces" as crucial factors converging to create a unique historical and social environment that enabled a place like Diabasis to emerge. All those forces, each noted by one or more of the participants, show that Diabasis was also a product of its times. Perry noted that his earlier attempt to raise interest in such a project (circa 1960) was met with indifference:

> Being impractical, sort of imaginative, idealistic—that's what they thought. It would have to be ineffectual. The medications were just getting under way at that time, and that seemed to be the new way to do things. I explained [my] view about it, and got a negative, and this pitch that there were better ways of handling it nowadays—the same thing we're getting today.

However, by the time he created the proposal for Diabasis, in the early 1970s, attitudes had shifted radically. Perry described the prevalent attitude of this later time:

> Good things happen in the psyche. Good things happen in all states of consciousness. People just seemed to understand. As soon as they heard about it, they agreed that it's a good thing to try. So, it did make a big difference
>
> So, there's that and then the politics. We didn't have to pressure a whole lot....Art Carfagni, who was head of Northeast Mental Health Services, at the time, was a master grant proposal maker. He liked the sound of it....it looked like a good venture and something he could get money for, and he sort of ran interference, so to say, and took care of all that part of it, in connection with City Hall. You had the feeling the whole thing was unfolding before us, with friends sending people they knew in connection with us. It just seemed everybody was

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> sort of facilitating. It was a very lovely feeling and unusual. So, the time was really right for it.

All participants referred, more or less explicitly, to the pervasive influence and legacy of the international counter-culture of the late 1960s and early 1970s, which, unlike the "establishment," placed a high value on imagination and idealism. J. noted that "the social and political environment of that time was supportive of that kind of milieu, that kind of whole philosophy." Vietnam- and Watergate-related political skepticism and radicalism fueled and emboldened those challenging the authority of social institutions in general, and the psychiatric establishment in particular. A. recalled that

> Vietnam was an insane war, and we had a president we all knew was lying to us, but it somehow didn't matter. There was such disparity at that time between the youth culture and the predominant culture. We didn't have Jimmy Hendrix selling Chevrolets as we do now, so it was quite a different world. We were both thoughtful people, and wacky people, really talking about madness as a different way of dealing with life.

B. also referred to the revolutionary qualities of the time:

> A friend of mine who was also studying psychology at that time said that the only plans she was making at that stage were to participate in a new world. I mean, we were also in that move to be on the barricades, or be at what we thought was the forefront of some new age.

Psychedelics and marijuana were widely used, adding to the interest in visionary and altered states of consciousness. Timothy Leary, Ken Kesey, and others advocated a "turn on, tune in, drop out" credo, epitomized by the influential San Francisco music scene and promoted by bands like the Jefferson Airplane—whose song, "White Rabbit," J. referred to in describing the atmosphere at Diabasis. A. remembered "going through graduate school having lots of shaky experiences... drug experimentation. There was somewhat of a fine line between the experiences of people with serious psychoses and the alternative culture."

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R. D. Laing's radical, existentialist, antipsychiatry writings on psychosis, Perry's own *Far Side Of Madness*, Szasz's *The Myth of Mental Illness*, and some of Jung's writings were "required reading," not only for members of the counterculture, but even in many colleges. Together, they became a set of almost canonical texts readily available to people interested in alternative methods of treatment. Laing's egalitarian approach at Kingsley Hall also set a precedent for the use of paraprofessional staff at Diabasis. Perry remarked he

> thought the best thing that Ronnie Laing had done [was to] popularize this notion of taking a whole new look at mental upset and suggesting that if they are allowed to go through what they needed to go through, that things could happen. Kingsley Hall...was a commune, not made up of people in a psychotic state, but from all different kinds of states, and we didn't want to follow that model. But at least it opened the way, and it did open the popular mind to that kind of possibility.

The intellectual influence of these authors combined with the counter-culture to create a welcoming environment for an alternative treatment program for psychosis. A. echoed Perry's comments:

> People were really looking for alternatives to the hospital inpatient model at that time. Especially for young graduate students, the psychotic state was really viewed in a somewhat romantic way. The literature was full of things by R. D. Laing and Foucault and others who talked about how madness was an alternative expression. The whole alternative culture of the late '60s and early '70s was really pushing the boundaries of conventional lifestyles and to *some* extent psychosis was almost seen, if not consciously, almost semi-consciously, by us as almost an inevitable creative expression of the madness that the world was.

B. also remarked on these influences:

> This was in the early '70s, and I got quite interested in ways of looking at madness, and what madness means to us, collectively. I guess the kinds of thoughts that were coming out—work that Laing was doing — generally it was a time really when people were looking not only at individual manifestations [of madness], but also the social manifestations. So, trying to get a way of understanding and recognizing the individual manifestations felt like one step toward recognizing the bigger manifestations.

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This cultural climate had a direct effect on the development of Diabasis through its more subtle effect on government policy. At the federal level, NIMH hired Loren Mosher, who had worked with Laing, to be Chief of its Center for Studies of Schizophrenia. Mosher, in turn, consulted with the planners of the Agnews Project. This project, as I discussed in the introduction to my study, resulted in hard evidence showing that alternative treatment of acute psychosis was much more effective than traditional psychiatric practice. Perry was able to use this evidence to garner support for Diabasis.

The counter-culture, with Haight-Asbury as its almost mythic center, was especially strong in the San Francisco Bay Area and may even have been spawned, in large part, by the Beat movement of the 1950s and early 1960s in North Beach. Perry described the area, even in the 1950s, as having "a unique kind of vitality, with a readiness for new influences and movements." He noted that San Francisco was already a surprisingly liberal city, where masses of young people responded with vocal protests to visits by Joseph McCarthy's House Un-American Activities Committee.

In addition, the national antipsychiatry movement, especially active and radical in and around San Francisco, supported a climate that favored the use of non-licensed mental health staff, as well as alternatives to medication and "psychiatric assault," as options for the treatment of psychosis. Former "associates" of the Agnews Project were working in nearby communities to create other alternative treatment programs: Mosher opened Soteria House in San Jose in 1971 and Stanley Mayerson opened I-Ward in Martinez in 1975. Perry noted that it "was among friends, each with his own vantage point and preferences, going off in his own direction." He himself was active in the

> Mental Health Association, I guess it was....They were doing all kinds of things politically to get funding and make planning. They were the ones who planned the

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idea of shaking out the state hospitals and supplying them with community hospitals instead.

In the 1960s and 1970s, movements also formed within psychology that gave attention to consciousness and transpersonal states. These movements, which emphasized Eastern spiritual practices, flourished in the Bay Area at the California Institute of Asian Studies and at the Esalen Institute in nearby Big Sur. The human potential movement, also centered at Esalen, popularized the work of Maslow on peak experiences, as well as Perls' Gestalt Therapy; Perls coined the hedonistic slogan, "I do my thing, you do yours," and emphasized a *satori*-like "living in the moment." Esalen sponsored an entire summer of workshops on "The Value of the Psychotic Experience" in 1968, where, in addition to Perry and Julian Silverman (also involved with the Agnews Project), presentations were given by major figures such as Stan Grof and Claudio Naranjo. Perry described seminars "all through the summer, workshops—weekend things, week-long things. They had a big crowd of people interested in this. So, the professional atmosphere was just alive with that kind of concern and interest." The founders of Esalen, Michael Murphy and Richard Price, were present at the initial meeting at Perry's office which led to the Agnews Project and they supported Diabasis directly, as did Esalen associate Gregory Bateson.

The uniquely tolerant and progressive political and intellectual climate in the Bay Area honored people like Bateson and Price (whose own psychotic experience prompted him to be a key player in promoting alternative treatment). Their enthusiasm encouraged politicians, such as Diane Feinstein and George Moscone, to support Diabasis; that support—along with the support of many influential people within the mental health system—proved to be a key factor in getting Diabasis funded.

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Perry noted that existence of the counter-culture created a large pool of applicants for Diabasis staff positions, who heard about them through the "underground telegraph." The counter-cultural climate, in the person of a young psychiatrist, Howard Levene, was even responsible for moving Perry himself in a more radical direction:

> I didn't know for sure whether we could have acute first episodes, with all the action that goes on and all the possible disturbance, with an open door facility, especially with a new staff that were not educated in this...not instructed in psychopathology. Howard and I were cooking this up together by this time. He was for being more radical about it. He said, "Forget it. It's been found already that people do well without the medication, so why fall back on that? Take the more difficult, the more risky way, but give it a full try." I agreed. So, we didn't even have a nurse on board—I thought, at first, we should have a nurse who had been experienced in this. Then we found ourselves agreeing that, really, we didn't have to do that.

The "counter-force" Perry cited as most distressing was not traditional psychiatry, but the San Francisco Jung Institute. The Institute initially hesitated to support Diabasis because they saw Perry as

> an intuitive type. They felt, "John's good at intuitive things." I had to tell them I had already set up many new hospitals, five times during the war. It was my job to get the real estate and negotiate with city hall, and gather the staff together, and establish a team and a medical staff, and then govern the thing. I did that five times over. But, my colleagues thought, "Well, intuitives don't do that kind of thing." It ticked me off. I was put out! [They were] brushing it off as sort of impractical.

Perry suspected that most members of the Institute actually had a much deeper reason for disassociating themselves from Diabasis:

> I didn't hear it voiced this way, but my guess was they didn't want Jungian psychology to be associated with craziness, even though Jung had started off on that footing, himself. His early work was with schizophrenic people. But I had an uneasy feeling that, if we [connected] craziness with Jungian archetypal formulations, it wouldn't do the so-called "Jungian movement" much good. I was annoyed with them.
>
> People were complaining that there wasn't enough [Institute] participation in community work, that we were too isolated. So, here was an effort that was really public and they didn't go for it. They finally did put up $1000 at some point along the way, but after it was already underway. Mostly [they asked]

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> negative, searching questions such as, "How are they going to manage the household?" "Do you have to have a clerk?"...and this kind of thing. "It's very complicated," and "You'll have to have medical facilities on hand"—this, that, and the other objections to the plan, rather than offering...to think about how to help it go.

I asked Perry if this attitude on the part of the Institute might itself have been a reaction to the "social forces" present in the 1960s. I mentioned that shamanism has now become a popular subject among Jungian writers and that talking about visionary states in psychosis in terms of shamanism may have given the topic more legitimacy. In the 1960s, however, Jungians may have responded negatively to the emphasis on "altered states" for their own sake. Perry agreed that, at the time, the counter-culture

> was using Jungian language to justify that whole enthusiasm for altered states, and I think they decided they didn't like that. As far as they were concerned, that wasn't Jungian psychology at all. [Jungian psychology] goes very deep, it's hard work, concentrated, and [the counter-cultural] picture of altering consciousness [as] simply healing in itself just met with complete scorn, from most everybody. In fact in Los Angeles, James Kirsch and his wife, Hilde, set up an Institute [and] they even dropped one or two people who took [LSD] trips...they fired some people. They were adamant that this was a misrepresentation of Jung. So, I think we fell into the shadow of [that].

However, as I discussed in the first section of this chapter, the Institute opposed Diabasis for using paraprofessionals as well. Perry described how he, with Howard Levene and Nickie Holbert (the social worker who served as Diabasis' director and administrator), made a presentation to the Institute on the work they were doing:

> As soon as we started to describe this method, they began to get angry, and then they argued with one another and interrupted us, as we were talking. The place was like bedlam, and Nickie came out of the meeting saying, "That was the rudest bunch of people I've ever talked to in my life. They didn't give us a chance to talk and they laughed at us and snickered in the corners."
>
> It was not rational. They were angry, really angry. That let me know that there was a lot of prejudice about qualifications....if you've gone through [analysis] personally [and] you've gone through it academically, that qualifies you to do this. And without that, you shouldn't mess with it. So I posed the question then, "How are we going to work with these people, in that case? If we took only

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> professional people to do the work, would you all want to do some of that? You've got all this training, you could." One guy said he might, out of 41....Which meant, in consequence, that nobody should do it if they are not trained and, therefore, nobody will. That appalled me.

Perry found it strange that his proposal for Diabasis garnered more support outside the Jung Institute, than it did within it:

> Even among psychiatrists. They were fairly excited about what we were doing. Langley Porter [at UCSF] was quite excited and sent us cases. People, the public in general, when they heard about it sort of could recognize it and say, "It sounds like a good thing." The Jung Institute was just down on it.

In addition to citing the social forces that made Diabasis possible, all participants referred to the current climate, which arose before Diabasis closed, as a block to creating such a program in the present. The shrinking economy and budget cuts eventually shifted the social atmosphere. From the national to the local level, mental health budgets were drastically reduced. Under budgetary pressure, Diabasis first was forced to admit patients who were diagnosed as chronically "schizophrenic" or depressive, in addition to those undergoing first breaks. This dramatically changed its environment. Then it lost its public funding altogether.

Foundation grants had not been available, even in the early 1970s, because the medical model had already gained hegemony over the discourse at that level. In the late 1970s, it began to dominate the local discourse as well. Perry noted that, in the current climate, attitudes towards alternative treatment are

> absolutely opposite. It's all regarded as not only "airy-fairy" but also dangerous; therefore, there's a lot of fear attached to it....the very idea of such a mode of handling "psychosis" rouses a particularly venomous hostility on the part of many psychiatrists.

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B. pointed out that the entire emphasis of "experimentation" now focuses on "refining the chemistry." She also remarked on the large differences in public funding, as well as a change in attitudes among therapists:

> I think one of the things that also has happened in mental health is that providers [now] set up an additional barrier between themselves and their clients—for whatever reasons, it is part of the self-protecting mechanism—and especially with people who are seriously disturbed.

J. wondered "if Diabasis would even be possible now. I think it was a reflection of the times." R. simply remarked that "I can't imagine how [Diabasis] came into being in the first place. And when I think of today's political climate...anything else than the material world seems to be given no value."

The Nature of Psychosis

The nature of psychosis itself constitutes the second major area of emphasis in the data generated by this study. It emerged strongly as an area rich in meaning for the interview participants as expressed in three main themes. First, participants repeatedly emphasized that psychosis is not a unitary phenomenon. Second, participants believed that psychosis can be a purposive developmental process: an auspicious (albeit harrowing), and perhaps inevitable, psychological crisis. This belief was confirmed by their having personally experienced—or having been exposed to (as staff)—unmediated (medication-free) psychosis. Third, participants believed that psychosis can be an experience with strong transpersonal elements. They described this transpersonal dimension of psychosis in three specific ways: in terms of archetypal or spiritual energies

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actually affecting Diabasis residents; in terms of shamanic initiation; and in terms of prophetic visions, potentially of benefit to more than the individual.

Participants believed that this transpersonal level of the psychotic process can exist in tandem with the more personal, developmental level; either or both can as offer an opportunity for powerful transformative experiences. They believed residents could be positively affected by the religious, visionary material thrust on them by their psyches or by "powers" working on or through them. Even though these experiences were also very harrowing for some residents—R. described part of her transpersonal process as being an uncanny experience of "supercharged terror"—they could have positive outcomes.

In his interview, Perry noted that, by its very nature, a powerful initiatory experience involves the unknown, which can include the personal shadow, as well transpersonal energies that are associated with the underworld, darkness, death, and destruction. As a result of not being medicated, some residents at Diabasis went through deep archetypal experiences that could be likened to shamanic ordeals, as I discussed in the introduction to this study. These ordeals left them familiar with realities quite unknown to their family members and friends.

The participants acknowledged the potentially terrifying nature of these ordeals, as well as the labor intensive and extremely personally intense experience involved for staff in treating psychosis without medication. All of them were aware that, over the last two decades, the medical model, as promoted by biopsychiatry and NAMI, has forced any discussion of alternative treatment of psychosis out of public discourse. Nevertheless, they all asserted that a place like Diabasis should be available today and

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that there is a significant gap in the continuum of care currently available to those individuals who could potentially benefit from a Diabasis-like milieu.

Psychosis Is Not a Unitary Phenomenon

Perry's theory of psychosis assumed that some people would benefit more than others from being treated in a setting where the "way" was practiced. In the interview, he talked about how he currently sees the differences among types of psychosis. First, and most important, is his sense that each patient is unique: "It comes out with a different personality each time, and very different from one another." Second, he sees differences in terms of salience of familial and transpersonal issues, as I will discuss in the latter part of this section. And, third, he sees three basic types of psychotic process, with different potential outcomes.

During his years of working with hospitalized patients, Perry purposefully sought out those patients with the most "activated psyches." These patients, like the Diabasis resident interviewed for this study, are already producing quantities of symbolic material and, according to Perry's experience, have an excellent prognosis. Some of them fit the picture of a creative person who may be able to manage her or his own process, given the correct setting. In this category are

> [some] very creative people that are just going through a [process] which is confusing to them. They shouldn't even be in a psychiatric setting. They should go to a retreat somewhere, a place very safe to be, and let the whole thing happen, and let it take a creative form, especially if they are artists...[we shouldn't] bother them with psychiatry at all.

Perry also described a "middle group" of these "activated" people who, in addition to needing a safe place, need therapy with someone who can "guide this process

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through to its conclusion without medication." Perry seemed to indicate that Jung's mid-life experience fell somewhere between this category and the first. He attributed Jung's ability to undergo it on his own to

> his immense energy. He just worked and worked to understand this thing. Understanding for him was a lifesaving thing. He made something of it and put it into creative work, creative thinking, creative professional work...a very hard way to go. He felt very, very lonely, profoundly lonely....He had very few close friends, [although] he had [some] women friends he could really open up with...Toni Wolff, for instance. [They] had to really work it out together, so I think he didn't get it from a therapist, but he did get it in his relationships.

He agreed that, because of the lack of the kind of treatment that Diabasis offered, people in either of these groups, despite having what he considered an excellent prognosis, could, if treated incorrectly, end up as "chronic schizophrenics":

> Poets, painters, philosophers...yeah, they got destroyed. That's the painful part of this whole story, that a psychiatric lack of knowledge...about all this has had the power to make things go so wrong. It has that kind of very destructive effect on some. I've heard of people who were very sensitive poets...who were put through that and just lost it, never wrote again. It's awful...an awful picture.

Perry agreed that the presence of a therapist who can accept polarities and who has a receptive quality might be a prerequisite for a successful resolution:

> In terms of judgment, inclusion and exclusion, accepting or rejecting, and that kind of thing, the person at the initial outset of a psychosis is hyper-alert to critical responses, to categorizing them as being in the wrong state of mind and going through things that have no value...mistakes, disorders. As soon as they find out I'm curious about where [their process] wants to go, the patient feels different right away, just from the very beginning. I think in that state of mind, the patient is more than usually observant, like a child. They see who's friendly and who isn't. Who's open and who isn't. So, yes, I think the state of mind that you come with, or the outlook that you arrive with for the interview has a great part to play in what actually transpires with that patient in her process.

Interestingly, R. spoke specifically of this sensitivity. She remarked that "you're involved in all this craziness, literally, and at the same time you're keeping track of [pause] you still have very good instincts about people."

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Perry went on to describe a third group of people undergoing psychotic processes who he believed probably required hospitalization. Such patients

> look different. The expression of the face is more dead. The eyes are empty, no lines around the eyes, and they're sort of staring...kind of mechanical and stiff and machine-like. [For this group to heal takes] much harder work. A case that's heading downhill—it takes a very great deal of concentrated effort over a long period of time to see that through...if they're going to get better. I think it's a lot different experience and takes a lot more skilled work. And then there may be some who just don't have it to integrate that...maybe they're so injured or maybe congenitally they're just not going to grow that much.
>
> There's a whole range of different capacities in [psychosis], but I think that it would probably break down to six or eight groups, more than three—three is very rough. The genes that they talk about in that inheritance, I've heard it described as genes for sensitivity more than pathology....Damned if I know....Until we solve the problem it will be more puzzling...Once we have a perspective on it like that, and know how to usher a person through while they're down, I think we can get a better handle on what the severely insane are capable of....I don't think there is a cure for everything, but I think it *is* good to have a range of responses.

The former Diabasis staff I interviewed agreed that psychosis comes in various forms. (I will discuss their comments in the last section of this chapter, on the retrospective critique of Diabasis, since all felt that their views on the variety of possible psychotic experiences had changed, to one degree or another, since their tenure at Diabasis.) R. also recognized a variety of "processes" at Diabasis that differed significantly from hers. She, for example, stopped being actively suicidal as soon as she found herself in a safe place, while other residents, who remained suicidal, required constant attention. She also compared her process to that of a resident

> who was *completely* in mid-psychosis, in the sense that she wasn't there at all. It was dazzling! I had never seen anyone like this. You could give her words, and she would transform them into a stream of incredibly brilliant literary allusions....It was at great fast pace, and it was truly dazzling and scary all at the same time. I knew where I was most of the time—except when I was being engulfed by my dreams and things, I still felt a thin membrane between the world and me. Whatever the membrane [is] that separates—I could see in her that it was gone or that it was barely there.

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Psychosis Can Be a Purposive Developmental Process

For those undergoing a psychotic process who fall into Perry's second category—having an excellent prognosis, but needing therapy and guidance—familial and developmental issues often come into play. Perry responded to my question about the comparison between an "underworld soul journey"—a particularly terrifying process—and an experience that seems both more "spiritual" and more manageable:

> I'm inclined to think that what makes it a hellish, nightmarish experience is that it's derived out of the family system, dealing with troubles that had come out of the family system. [A person in that situation has] to regress to that level to work that out, with very intense emotions and a good deal of acting, almost like a dramatic form to give expression to all that, as she works through it... she has to go back into the very heart of that very earliest level to work out some of those things. If the cultural and familial system are both points that have been very hurtful and contrary to the nature of the individual, there's a greater chance then of a very painful, disturbed kind of journey through this...I think it's just that the problems they have been taking on constitute it.

From the perspective of both A. and J., most of the Diabasis residents fitted into this category. A. described the tendency of residents to go

> through cycles; they would go through period of withdrawal and periods of agitation and periods of some form of explosion or other. We really tried to make an environment where all of that was possible....There is no question that for many of the clients there were very many painful periods. We didn't try to shy away from it. Again, the concept was that this was a necessary process to go through, and we didn't want to shield people from the inevitable pain that was coming up.

J. reinforced A.'s sense of the Diabasis clients as involved in a necessary and purposeful developmental process:

> I saw psychosis as a regression. That's why it's good to have a framework [like] John's system, that journey backwards, that you can come out of it better than when you went in. I actually saw them [do that]. I thought that it was a very intense, painful, negative state...but that it was almost like they had to go back because wherever that came from, it was a handicap.

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R. described some of the developmental factors that she was dealing with that were relevant to her process at Diabasis. In the parts of her interview I cited in an earlier section of this chapter, she described herself as qualifying as a lawyer. then finding herself unable to function as one. She elaborated on the "developmental crisis" aspects of her situation:

> It had been a very, very directed effort from at least college...probably before college...I had put my life [pause] I would keep trying to think about doing other things, I had spent a good part of my adolescent and adult life working on being a lawyer, I could not really accept that I was not going to be one. So, I continued and eventually my inner world swallowed me up. It came out and demanded [that I give it] attention—or [I would] just die in another way.

R. explicitly sought to protect herself from contact with her family during her stay at Diabasis:

> I attempted to cut it off and I wanted no contact. My family was on the east coast and I came out here to go to law school....My feeling about going to Diabasis instinctively again was going to this place—I'm not sure I experienced that this is what it was at the time, but in trying to describe it backwards like this—that I was going to this place in which it was for *me*, and not [pause] I wanted to be free and not have to explain to my mother—in particular to my mother, but also to my family—what I was doing here, why I was there, what the place was like. I'm sure I didn't talk to my brothers. I have two brothers. So, I wanted to not connect with my family.
>
> I'm not sure if I called and told them I was going there or wrote them a note, but my mother called. I think I told Lynn I didn't want to talk to her, so Lynn told her. I think she called back, so I think Lynn finally called her and had a long conversation with her and Lynn told me later that [my mother] was frustrated....I could tell that my mother was hurt...that she wanted not to be cut off...

R. was aware that her process at Diabasis was a way of separating from her mother:

> My mother was also a very intuitive person who probably had a very rich inner life that she had wanted to explore. She had very strong irrational parts about her and she and I connected on that level in a very silent and communicative sort of way. So, I think that she had some sense of what I was doing and that it was probably to kill her [symbolically] in some very irrational sort of way.

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> But, she felt it as an exclusion; whereas, my father looked at it as some sort of medical treatment. He knew there was something slightly different...I think they did give me some stuff and I just put it in the mail to my parents with a note or something, as the best way to explain it. So, my father accepted it as some sort of, if "slightly San Francisco," at least medical program that had some solidity to it. [He] could approach it in terms of a rational thing.

Reflecting Perry's sense that particularly frightening breaks involve a conflict between the individual and both familial *and* cultural systems, R. found herself in a situation where pressure from her inner world forced her to separate from her family and her profession at the same time. Although she never mentioned pressure from her family as part of what drove her to be a lawyer, she did mention that her childhood environment devalued both art and inner life. This devaluing led her to give up painting as a child, rather than continue to pursue what, after a successful resolution of her break, she recognized as her vocation.

Psychosis Can Be an Initiatory Process with Strong Transpersonal Elements

In describing her first encounter with madness, J. noted that the patient's "face would change. He would be an angel one minute and the devil the next." John Perry also referred to these polarities in relating that his initial awareness of the transpersonal aspects of psychosis was rooted in his early questions about the psychic function of Christianity:

> When you're dealing with polarities and cosmic conflicts and all that, the aim [of the psyche] is always to get to a point where they're resolved and come to terms with each other somehow. [The Judeo-Christian response to polarities] is that the polarity is in the nature of things. It's just there. It's God and devil, good and evil, and sin is always present, it's always the enemy, and the idea of resolving the opposition doesn't seem to—it was there in the original Christianity, but by the time the church got a hold of that, [it] dropped away. So sin is something that you fight against all the time in traditional ecclesiastical Christianity.

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> In original Christianity, it was something you forgive and you get free of. That's different. That was much more like [a] spiritual formulation. In China, by the way, you never heard about evil. There was a dark principle, there was difficulty maybe, but not evil, not that sense that there's anything like a Satan wandering around the world causing trouble like that. I got the impression, from [the Chinese] point of view, that the higher you set up this Christian virtue, the more you create at the same time a deep shadow to it. It's almost as if sin and evil were a by-product, a spin-off, from the lofty Christian virtues. So, I was getting some radical sense of that—polarities and transcending polarities—already by the time I got to Zurich.

In working with the patient at McClean, whose case he wrote up in *The Self in Psychotic Process*, Perry discovered that these same polarities were

> a big part of her process. It wasn't just a two-fold polarity, but a four-fold polarity finally, and these poles all meet at the middle and conflict and war against each other, but right away they resolve the conflict and end up in unity. She was clear in her psychosis at that time. It spelled itself out very clearly, that the psyche's work is to transcend oppositions like that.

Perry came to understand that a psychosis, which originates in a "central injury" and serves as a developmental crisis, may open a person up to an archetypal process that has a life of its own:

> All those difficulties and hurts and traumas were, from another standpoint, the occasion for the psyche finding itself. You've got to still remember that in order to get to that true Self, there will be some sort of turmoil around it, and for some people, it happens to come in this form: they had a dreadful childhood and had to cope with that and grow in spite of it, and that process got off on that footing. A lot of these are very spiritually gifted people that got into a psychosis—if it goes right, they come out with a lot of energy freed up for good creative work.

I asked Perry whether he believes that visionary states or psychoses are inevitable during "times of trouble" and cultural change. I also asked whether he believes they serve a collective function, in addition to that of individual healing or renewal. He responded by describing his impression of the 1960s counterculture:

> I think the phenomenon of the '60s and all the counter culture really impressed me, in that I was seeing the same thing out at the Haight-Ashbury that I had seen in County Hospital...there was a messiah on every street corner in the '60s

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> around the Haight. I don't know if you were around then, but, almost literally, there were little clusters of people here, and there, and there, and there, with world mission desires and those kinds of things. So, it was rampant. And the whole pitch about letting go with love and letting it really do its work and getting free...that's really the same pitch, the same process, the same considerations, and the same message always, again and again. In the '50s I was watching it brew below the surface, and in the '60s I was seeing the same thing out in the open.
>
> Then I began reading about prophets, prophetic visions, and social reformers who have their visionary experience and go through that same process and change their culture—become charismatic. So, it seemed to have that implication that the real role of the visionary state was not only to reform the self, reintegrate the self, but at the same time it was part of work of the culture too, *for* the culture...

Again, Perry referred back to the relevance of his experience in China, in helping him develop a rather non-Western sense of the meaning of "transpersonal":

> That's another thing that was in [Chinese culture], so I was all ready for this by the time I got to it. All Chinese philosophy right from the start had to do with how to live in society and how to govern society. It wasn't separate individuals going through their own thing. It was entirely within the framework of social participation, social organization, including social reform. That surprised me. Then, when I read about Asian myth and ritual [it] was always about government: the Pharaoh and his rituals, the divine and sacral king in Mesopotamia, and even in the Bible, with the kind of thing that David and Solomon were about, and the prophets—it all had to do with government. Essentially, it meant that religion was about politics, in the real sense of politics.

Perry said that this refined insight about the political function of myth and visionary states led him to

> a somewhat critical attitude about the Jungian slant toward the isolated individual...the person who is fulfilling himself or herself and in interaction daily with other people, but very rarely considered as part of the whole trend of the culture. I think Jung was more aware of that than most Jungians that I was reading. I was getting a picture that each of us carries around the image of the culture inside our own heads...not just a picture of it, but a dynamic thing going on in our psyche that represents the culture and our relation to that, and having to heal that experience of the culture as much as heal our own difficulties with growing up within our families. Then, the broad picture is that we see an individual in therapy, or a few individuals, and if you put that out over the whole nation, 250 million people, many of whom are going through this inner process, you've got a picture of this collective psyche...a lot of stuff that is brewed in there takes cultural form...

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I asked Perry if he found it poignant or tragic that people in our culture, who may be the antennae for new things that we need, are being numbed—that current treatment "turns down the volume" on what they can say. He responded:

> The way we're handling these people, we're silencing what the visionary experience wants to do and, if that's the case, then we should set the whole intake system up in such a way that it gives everybody a chance to let us know whether this is a process that wants to happen, and then [if it is,] let the visionary stage express itself...[There are] religious people who have been ashamed of [the process] and needed to avoid it because they were [seen as] irrational and schizoid instead of religious. You look back in history and think of all the people who would have been hospitalized in these times. It's pretty dreadful! We stand to lose a great deal of valuable visionary experience if [psychiatrists] keep doing what they're doing now. What chance does a visionary have to be visionary? You just can't do it.

Perry told a story about a man who had managed to find a way, outside the psychiatric establishment, to allow the visionary process to express itself, much in the manner of a shamanic initiation:

> He had done some work in therapy here for awhile...then he moved to the Southwest. Then some years later, about a decade later, he had a psychosis and he chose to hole up at a little cabin out in the prairie somewhere. He had some friends who brought him supplies, food, and just monitored him, making sure he was doing all right. But, he was alone much of the time, holed up, I think it was half a year...and suffered, but came out very wise. He educated himself about the Southwest to the point where he became a kind of wise man and all kinds of graduate students came to him to learn about Native American culture. His face was all wrinkled, like an elderly oriental face, all crinkled up and open. He really got opened up. That was the hard way.

In following up on the issue of individuals carrying visionary experiences for the culture, I asked Perry about the content of the polarities he saw in psychoses, at Diabasis and since. I specifically asked about reworked images of gender and images of what some Jungians are calling "the return of the Goddess." Perry responded by describing a woman with polarities

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> concerning the feminine deity, the one that is identified with the Great Mother, Cosmic Mother, but is very hostile to the male rational principle that creates an industrial or scientific society. She really wanted to get back to a sort of Neolithic Earth Mother and culture—everybody living in homes and turning factories into apartment houses. That was a very urgent rousing of the feminine in her over against a lot of influences that had come in the family and from the culture. [For one woman] with a Great Mother identification, all of the men in the world had been eliminated but one, but their sperm was kept in jars so that reproduction could go on. She had the population of the world reduced to three women and one man...so gender was very important thread that ran through that whole thing, [she] had to readjust the proportion between them. [For another woman] all the feminine women were going to be sent down to South America where they belonged, so to speak, and the Mexican women kept up here to deal with the men.
>
> [In] the male counterpart of that, it seems...union of the male and female is the principle motif, I think, not really following a male deity by himself, but usually trying to get the two genders into some sort of resolution—a creative state between them. So, gender is something that is constantly being reviewed during the process....It gives you the impression that the deities of our new futurists are going to be male-female. That's not a new thought; a lot of other people are saying that. I used to have that in my [dreams] in Zurich, so I was ready for that kind of image.

Perry also described the resolving of existing political polarities as having been a major concern for people undergoing the psychotic process. He said that he was

> very curious to know how that would look nowadays...whether that's a prevailing kind of image. I imagine it must be. Russia and we are no longer enemies, so the world isn't divided into these two geographical factions any longer. It would be very sensible that the important issues now are about the earth, about the planet...more in terms of environmental issues—polluters and environmental people.

Perry suspected that the environmental crisis would be the seedbed of the myth now prefigured by the content of visionary states:

> To enter a whole new myth form—we need that in order to get new bearings in a new crisis, really. All those historical studies taught me that mythology is born out of crisis...out of the real urgent crises of change—economic change, lifestyle change, social change, all those. Change is disorienting. You don't know how to go about things. The old ways were patterned and traditional and...suddenly, you don't know what to do with this new thing. The myth seems to be a preparation to open up that future...
>
> Then, the new myth form deals with very current issues, and the images have to be in the language of present day concerns within the new myth. So today,

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> since our greatest threat to our existence is our relation with nature, that would be the natural myth form that would take shape, it seems to me....It's still unfamiliar and urgent. That's when the myth is doing its work, to try to get an orientation to this thing.

While he agreed that the Gaia hypothesis (Lovelock and Margulis, 1974)—that the entire biosphere of our planet is an organism—is "already a myth form, and it's something that is uncanny," Perry also argued that

> nobody could sit around and figure out a myth, you know. Nobody knows what the hell is next, what the myth is going to look like, because it's all unfamiliar territory. The answers that might be proposed from the psyche would be totally unforeseen. The language in which it may be expressed might be quite new, just so that you can't anticipate a dream of it. The psyche is brewing [the future], and we're going to find out from the new myth forms that come up what the whole thing's about. Where it's supposed to go.

Perry expressed agreement with predictions that we are headed for "a major shakedown of what we're used to in urban civilization." However, his optimistic view of the psyche gave him

> faith that the psyche has resources and even a plan, maybe, with all things. That when things get to this kind of pass, where we are now, the psyche is already trying to work out some way of transforming it, through disintegration, toward reintegration, like a psychosis. I think it's like a collective psychosis, a cultural psychosis. I think the evolutionary process...wants to go on, intends to go on, and it operates through chaos theory. It operates through phases of disintegration into reintegration... I would expect it to represent itself in [mythic] form so that we know what's happening. Not only know—the myth brings motivation along with it, so that we participate in what's happening.

Perry suspected that this myth would not emerge, as it has in the past, through a major prophet or redeemer figure. Instead, he expressed a belief, consonant with the vision which has guided his life, that

> it is the job of everybody, all the people who are alive to these issues, to participate in this, and be the agents of the new myth formation, the new visionary experience....The archetype of the Center—let's say it's the chief motivating, governing, psychic force of this whole change. It's not like a center that's out in space anywhere, it's centered and located in millions of individuals

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> and in their work in interaction with each other—like indeed, a collective psyche. Many centers, all representing one Center and forming a whole.

Perry believed that the Self, or archetype of the Center, was the source of the *agape* love that he experienced in his youthful vision. When I questioned him as to whether the new myth will resemble the "light-oriented" vision of the current New Age movement, I mentioned Jung's haunting prediction that the coming age will be that of "psychological man [*sic*]," during which we will each become aware of our individual capacity for evil. Perry acknowledged that much suffering would accompany the creation of the new myth, just as it accompanies the individual Renewal Process:

> If you take our experience of how many people are aware and how many aren't, probably five percent of individuals are concerned with spiritual development or a healing consciousness [and] participate in the maturing of that image. The rest are not bothering with it very much. [Maybe,] if we're going to reach a next stage, it has to be a leap by way of a lot of evil first...that those dark forces of disintegration get unleashed and tear things apart before we can reconstitute a new way of being. I think the shadow side...has a job to do, if chaos is part of founding a new order, then I think the dark force would be the age of chaos to do that. [Without it, we] would be asleep, sort of like Adam and Eve, passive and being fed by the deity, without consciousness...without language...

All of the staff participants also referred, to one degree or another, to the possibility that psychotic experience may have transpersonal elements. A. said that "some oracular, creative madness type things happened" at Diabasis that, rather than merely representing individual developmental experiences, may have been applicable to the broader culture. He also spoke extensively, as I showed in an earlier section of this chapter, about psychosis as an expression of the "life force."

B., who jokingly suggested attempting to create a DSM category called "Inconvenient Prophet" or "Annoying Visionary," said that she

> always felt that people who carried that carried it for all of us. I didn't know what its *function* was for all of us, but I felt that we all were an entity—humanity is a

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> something. So, the people who went through that, which was really very, very difficult, somehow they were doing it for me too, and I took it very personally. I still think that that is the case; I still think that humanity is an organism. And madness belongs to all of us.

R. also referred explicitly to the transpersonal content of the images and symbols that overwhelmed her. When I asked her if she would feel comfortable sharing a little bit of the specific content of her inner imagery, she shied away from doing so, saying that "obviously I am talking to you because Diabasis was a very positive experience. But I would have to think about it. I'm not sure if it needs to be a secret or not." However, in more general terms, she was able to describe images of

> being swallowed up, but also being offered things. I was being offered gifts which, at the time, I wasn't sure were gifts. At the time, they were very threatening to me. The dreams had a very powerful mythic quality about them—it wasn't like I was dreaming I was going to the grocery store or a picnic. They were very thick dreams, and they were...another very real part. Obviously, I valued them a great deal....I have dreamed, subsequent to that, dreams with those symbols, but only rarely, I think, of that proportion of magic. *Now* I can say "magic" or mythic qualities, but then I thought...in terms of some universe within myself that I wasn't sure I wanted to be in, but recognized as being a very powerful place.
>
> I think Diabasis, more than anything else, means both the recognition of the value of my own internal symbolic process—it sounds too abstract—but also the necessity of it. I was living a life on the margin and not making any use of that part of myself, until it finally just overcame me. So, Diabasis, for me, very much symbolizes the power of dreams in the most mythic and personal sort of way. Because Diabasis was very dream-like, when I think about it. And it did provide me a time and space to recapture something about myself, to try to capture a little bit of that part of myself, and to try to carry forward with it, to something that would be *me*, in a *forward* sort of way.

She also talked about the compelling and inexorable nature of the process, which forced her to come to terms with the Self and its priorities for her:

> The internal world [had become] something that in a way had less value...I mean, it didn't *have* less value. I always knew, even as a child, that that was the only part that counted, but it wasn't ever communicated to me. I never communicated it to anyone else that that was the true dimension I operated in. So, that kind of dual life—living with that personal connection but not connecting in any way, and

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> also choosing a day-to-day life that connected not at *all* with my real life—was ripening for a clash.
>
> The dreams were beyond saying, "Pay attention." It was like, "Look, you *have* to be paying attention, so don't even get set, this is it." For me, the being overwhelmed was a very necessary entry into another world, and for me it connected with lots of things. I think that Diabasis was a part of the whole and that my needing Diabasis was a very powerful link....I said I painted as a child. I was very much more aware of my inner world to a certain point. [At Diabasis,] I started to connect with those parts of myself and maybe that's what I meant when I said the dreams felt more a release, that the strictures in which I had been working were very much lessened.

R. expressed her belief that, if she had not been allowed to go through the process, she would have returned, again and again, to the psychotic state:

> I can see now that if I had instead been sent to a hospital and been drugged up for a few days and then let out, then it would have been a circuitous process. Maybe I could have recovered to the point of continuing to plod along in my work. But it wouldn't have worked. Something would have happened, either physically or emotionally. It wouldn't have produced what I needed to produce.

Instead, she was allowed to use her psychotic process to reconnect with the gift she brings to the world: her painting. She ended her interview by saying, "My spiritual practice is my studio, and that is the most important thing in my life."

Diabasis in Contrast to the Medical Model: Critique, Reform, and Repudiation

The third major area of emphasis I discovered in the participants' narratives involved a critique of the medical model: the treatment approach to psychosis practiced at traditional settings in the Bay Area and elsewhere. As one would expect, both R. and the staff participants, having been involved with an alternative facility for treating psychosis, compared and contrasted its theory and practice with that of the traditional model.

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This third major area of emphasis revealed responses divided into two main themes: (a) Diabasis was distinctively different from traditional facilities and treatments for psychosis; and (b) Diabasis was an attempt to reform, or perhaps even repudiate, the medical model. Since most participants addressed these two themes simultaneously, often implying the second when discussing the first, I will also do so in the following analysis, in order to avoid repetition.

As I demonstrated in the earlier section of this chapter devoted to social forces, all staff participants viewed themselves as allied with the antipsychiatry movement, which insisted that traditional practices were abusive and violated the human rights of patients. They cited the then popular writings of Jung, Laing, Szasz, Foucault, and Perry, which described altered states of consciousness as potentially liberating, and they espoused the Laingian view that psychosis may be a sane response to an insane culture. As a result, they rejected the medical model, which sought to repress psychosis, and embraced the Diabasis model, which sought to support it and facilitate its resolution.

Participants compared Diabasis to facilities such as state hospitals and the acute wards at Langley Porter Psychiatric Hospital. They discussed their general impressions of differences in diagnosis and treatment, as well as describing differences in a broad range of specific categories. These included: (a) value placed on the "inner world;" (b) physical environment; (c) intake interviews; (d) freedom of choice given to residents; (e) staffing policies, including the use of paraprofessionals; (f) relationships between residents and staff; and (g) specific treatment practices. All participants agreed that Diabasis offered itself as proof that alternative treatment of psychosis, using a Jungian depth psychology framework, was superior to traditional settings.

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General Critique of the Medical Model

Four of the five participants grounded their critique of the medical model in their personal experience working on or visiting traditional psychiatric wards. A., who had no experience with such environments, nevertheless offered a general critique of the medical model's diagnostic attitude. He discussed the basic policy of the Diabasis program, which accepted only patients undergoing an initial psychotic episode, in hopes that early intervention would arrest the slide into chronic schizophrenia. He then offered a critique similar to the point I made in the introduction to this study, when I showed that the Agnews Project findings undermine the automatic use of the retrospective diagnosis of Brief Reactive Psychosis to explain why some people who have psychotic breaks do not become schizophrenic. A. remarked:

> I think it was between DSM I or II, when we were at Diabasis, that Schizophrenia was getting redefined as that condition from which people didn't get better after two years. In a funny way, just through an operational definition, Diabasis became irrelevant, because people who were treated at Diabasis and got better, now, by definition, really weren't sick. So that almost made moot what we were doing, at least from the narrow scientific perspective. If you redefine as schizophrenic only those people who don't get better, well, if you make somebody better, then they weren't schizophrenic, and you're not treating Schizophrenia. That's such a solipsistic argument that I don't even know where to get in on it.

R. compared her memories of enjoying herself at Diabasis to her impressions of a traditional psychiatric ward, where she went to visit a former Diabasis resident after the program closed:

> I guess somebody told me about it and I went to visit her. It was the first time I had been in a psychiatric ward of a real hospital...it was really creepy! Nobody there enjoyed themselves, for sure. My friend was really doped up. The whole place, even the nurses and the staff, were really creepy, in the sense that there was no connection to what I'm speaking of, in terms of Diabasis. It was much more of a guard for physical danger: "Are you bringing in anything that could be a threat?"

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> As I remember, there was no private place to talk. She just had a room with four beds and we sat on the very edge [of her bed] and there were people coming in and out, I guess to find out whether she had hung herself. There was no trust in the place, no caring, and no connection on any level. I *did* enjoy myself at Diabasis and you certainly can't do that in psychiatric wards. Maybe you can only do it if you are in the other end and you're totally immersed in yourself, and you're not at all connected with the process...but I'm sure they get you.

Both B. and J. had worked on traditional psychiatric wards before Diabasis and were critical of the treatment situation in general. J., whose impressions of Langley Porter I related in an earlier section of this chapter, also remarked that

> I saw a lot of what was wrong with that kind of medical model. One of the things that I realized was that...during that time there was a gross abuse of phenothiazines—thorazine, stellazine, the main drugs for psychotics—and then they would say, "Well, we tried everything." Then, if that didn't work, they were sent up to the shock ward. I said, "This doesn't make any sense." Or, when people got really psychotic, they were put into seclusion. When I was working there part-time, my office was right next to seclusion, so I would listen to what they were saying. *I* thought what they were saying was making sense and that, if only people would listen, instead of isolating them during their psychotic episodes, they would get an idea of what the core conflict was right in their ramblings, because in their ramblings you could pick up a thread. So, [in going to Diabasis], I went from one extreme to the other.

John Perry also offered a general comparison:

> Through [Agnews], I learned, again, that doing this in a hospital is not so great, [as] there are a lot of things that you have to contend with: the administration for one, and the nursing staff that doesn't quite get the point, and a setting that said, "This is illness and this needs hospital care, and medical facilities, and medical help to handle it." Altogether, the right sort of thing for sick people and not for the people that [you want] to work with.

Value of the Inner World

These comments reflect the most dramatic difference between the medical model and the Diabasis model: the value the latter placed on the inner world of the person undergoing a psychotic episode. While I have extensively covered participants'

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impressions of this aspect of the Diabasis approach in earlier sections of this chapter, I will include here one comment by R.:

> I don't know exactly how it's communicated because, I never saw a manual about Diabasis, but the inner world really had enormous value. I had started to paint. . . as a part of therapy before I had come to Diabasis. In Diabasis, Lynn, in particular, encouraged me and we painted together. I covered the walls of the room, which was a very large room, with paintings. That also was very important in terms of expanding painting in terms of finding a language in which to find my bearings internally. Diabasis was a place to really focus on that....I can see now the seed that had already been planted in terms of beginning to paint—and beginning to recapture some of the joy of painting that I had as a child, and some of those feelings—at Diabasis, they could germinate and multiply and I could...just truly do it.

Physical Environment

The physical environment of Diabasis met Perry's criteria for a home-like setting, as different from a hospital as possible, which would facilitate practice of the "way." When he first saw the brownstone that Diabasis would occupy, on Pine, near Leavenworth, in San Francisco, he realized that "it was ideal—three stories, 22 rooms, Tudor outside, and sort of mellow inside, with wood paneled rooms and fireplaces in four different rooms.

R. described her first impressions of Diabasis:

> The moment I stepped into Diabasis, I really was happy. Nothing had even happened yet. All they did was open the front door...it just looked like one of the apartment buildings, one of the small apartment buildings. I just felt very relieved to be at this place. I remember [the intake interview] was [in] just a simple room. I don't know even if there were chairs. There may have just been pillows on the floor or something.

J. confirmed this impression, relating how the environment at Diabasis compared to Langley Porter:

> The whole atmosphere was planned—waterbeds, couches, pillows--and it was really a warm place. It used to be a Victorian flat so there were fireplaces and a

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> nice kitchen. Good coffee—that's where I learned about good coffee, and wine with dinner, and all of that. The whole atmosphere was created like that.

In an earlier section, I related how strongly R. felt about her room at Diabasis. She also commented that it was contrary to what she had expected in a treatment facility, and that she was surprised because it "had a little fireplace in it and big windows. It was a big room. In fact, I wasn't sure I could have it, because it was too nice of a room, but they told me I could."

Intake Interview

R. described her intake interview and how different it, too, was from what she had expected:

> I remember, at the interview, two staff people. They seemed to be people my age. There was also a woman there that I only saw one or two times since then. It seemed like she was an older woman and I think she wanted to know if this was the first time I had had this kind of contact with my inner world. So we talked about that....they didn't ask me questions like, "Who is the president of the United States?" "What day is today?"—those kinds of specifically medical "Are you here?" questions. They asked me why I wanted to come...they asked me what was going on and so I told them some of my dreams. They listened very carefully and then Carol offered a comment on the dream and then they asked me some other questions, I think about my inner life in a way.
>
> I found it very interesting, even in my scary sort of state. I didn't really know what they wanted and I didn't know what I wanted from them, but it felt like we were talking about the right kinds of things. I felt like I was telling them true secrets that could only be shared with a few people, and that they had similar kinds of things. I don't know exactly how they did that...I think there was a quality of attention and a quality of not being afraid themselves and not taking notes and I don't know...lots of clues...

Freedom of Choice for, and Trust in, Residents

R. stressed repeatedly that Diabasis gave her a "feeling of incredible freedom." The one rule she remembered with appreciation concerned length of stay: "There was a

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set period of residency so that it wasn't a matter of after two weeks they could say, 'Oh, that's fine, go home now.' I liked that."

The only other rule R. remembered was one that denied her access to the third floor, which housed the administrative offices and meeting rooms (after purchasing the brownstone, Perry had it renovated, so that the third floor was accessible directly from the outside). This, according to R., maintained "a real separation between administration and life." Commenting on the general lack of rules and structure at Diabasis, she said,

> I don't know if anyone ever explained to me how Diabasis functioned. They must have given me sheets of paper or something to read, or a consent form. I don't remember that part, but I don't think anybody said, "You'll be assigned two primaries and you will be doing this, and you have the right to this, and you can do this, but you can't do that."

By mentioning several times that she had been allowed to chose her own room, she conveyed the impression that she was still amazed by this. She also described being allowed to reject one of the therapists assigned to her:

> I was told that I was going to have two people assigned to me and one of the people was someone that was at my interview, a man that I didn't like. I guess it wasn't dislike, it was just disappointment, I think because I didn't think he was a strong enough soul. I thought he was a nice guy. I think I told [Lynn] I didn't like this guy. In social situations, I probably wouldn't have done this, but there was something about being given somehow implicit permission to move one's "process." I don't know exactly what happened, but I think there was a third floor meeting and I was finally assigned Mark, which pleased me.

As the staff participants mentioned in as earlier section of this chapter, Diabasis had an "open door" policy, unlike the locked wards of traditional psychiatric facilities. R. described her impression of this:

> We could leave. I don't remember exactly what the rules were, I guess we had to come back at a certain point, or check out, or something, but I remember going down to Polk Street and feeling I was in a totally different universe.

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Residents had free run of the kitchen and R. commented that, "We sometimes baked cookies together or helped make meals." She also described being trusted to have a fire in her fireplace, despite a history of having been suicidal:

> They had been told that I had been previously suicidal, so, after two days. I was told I couldn't have a fire. I was very upset. Then, I think someone told me [my history of feeling suicidal] was the problem. I was shocked. Here I was in Diabasis and they were going to tell me that! I wasn't going to kill myself! If I were going to kill myself, would I do it at Diabasis? It seemed to me like they didn't know this. Then I was told I could [have a fire] if I had a screen. Then some of the other staff people said that it didn't matter to them, so I don't remember what I did then. Maybe I just got a screen, or maybe they found a screen.

As I discussed earlier, R. was also allowed to refuse contact with her family. She commented on the freedom and support given to residents in choosing whether or not to relate to their families:

> They didn't [have an agenda to do family therapy]. Now that I think of it, I do remember a family conference [for] another resident and I think she wanted it. Or she may have been just been physically ill and I think they had a family conference to discuss what to do....[And when my family] called, Lynn just took care of it, because she knew I was upset. But [Diabasis] didn't call them and say, "Don't call your daughter." [I was] feeling imposed upon by mother and not wanting to talk to her and not being able to deal with it as well.

Staffing Policies and Lack of Hierarchy

Staffing policies at Diabasis differed dramatically from those at medical-model facilities. Many paraprofessionals and volunteers worked at Diabasis in positions of responsibility. Staff members were hired based on their perceived ability to practice the "way," rather than on the basis of normal job qualifications. B. related her memories of the unusual group interviews used to select both paid and unpaid staff:

> First, they had a whole series of group interviews, I think on Dolores Street. I don't know whose place it was, but there must have been, on the evening I was there, at least 40 people. They were invited to introduce themselves and say something about their motivation for doing this type of work. Apparently they

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> had several such evenings. [Then] they invited back maybe another 40 people out of the whole collection, for a second group interview, and that was in Berkeley, at Davey's house...I believe there were three interviews. Yes, the third one, which was also a pot-luck dinner, was maybe in Marin some place....Imagine a job interview in which everybody competing for the job gets to bring a dish for dinner, and state their case! It was a memorable experience.
>
> I was one of the chosen few. People who wanted to volunteer also went through that process—it wasn't just the paid staff positions, the rest would be staffed by volunteers. But I got one of the paid positions. I needed to get paid because I was actually supporting two kids.

Perry elaborated on the rationale behind the interview process. He described it as being designed to select those applicants who would be able to relate to residents in the special Diabasis "way." When applicants were interviewed by Perry and the senior staff, he noted,

> some of them had read all about it, had enthusiasm, were saying all the right things, but somehow it didn't come from the right level. It was like from the top of their head. It was surprising, but all the interviewers would feel the same thing. It was very subtle, we felt it intuitively, without words. Each time we didn't select someone, we all had felt during the interview that they would not be able to be there, in that certain sense, for the residents.

Once hired, both paid and volunteer staff found themselves in a work situation quite different from the strict hierarchy maintained in traditional facilities. In an earlier section, I cited J.'s comments on this situation, which allowed her, as an administrative assistant, to be completely "in the mix" and to feel supported in working with people in crisis.

R. also commented on the unusual staffing situation, including her observation that people who worked at Diabasis were also "there for themselves":

> Now, I can guess that they each had their own processes in the process. I guess to work there you had to be at a certain level of disconnection from your own process, where they didn't have to worry about you as well. I don't know. It's not like I sensed that they [pause] but I know that when Diabasis closed, it was very hard on everyone, even for the staff—[even] staff people who weren't paid, I would imagine the larger part weren't paid—to lose that connection.

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As I noted earlier in this chapter, R described how one staff member would do the grocery shopping once a week and how this became an "event" for both residents and staff. She also discussed the large number of staff, in relation to the number of residents, and the environment this ratio facilitated:

> It wasn't like a hospital where everybody had their assigned role, like, "I'm the physical therapist," "I'm the art therapist," "I'm the chef," "I'm the dietitian," except for your primaries, that you might have specific times to meet with. The other people—I still don't really know exactly what they did. I think they filled the house and were there for the residents, in general, but I'm trying to guess now. They created somewhat of a family sense. They all had different tasks. I never figured it out for a long time, but there were people who would just come one afternoon a week, or they would just come and cook.
>
> Now when I think about it, [it seemed like] there was a phenomenal amount of staff. I guess in terms of paid staff, there probably wasn't a great deal. But in terms of people there who were considered staff—I know they assumed staff responsibilities of one kind or another—there were lots, considering when I was first there, there was myself and this one other woman [and later] maybe five [residents] altogether, including myself.

Relationships Between Residents and Staff

As I have shown in earlier sections of this chapter, all the participants devoted large parts of their narratives to describing relationships between practitioners of the Diabasis "way" and those they served. All referred, explicitly or implicitly, to how different these relationships are from the relationships maintained in traditional psychiatric settings. J. commented directly on this issue by saying, simply, "Having worked at Langley Porter, I think a lot of people [who work at psychiatric facilities] are just scared of that kind of stuff [i. e. psychosis]."

In addition to the statements I related earlier, involving issues such as self-disclosure on the part of the staff, R. also said,

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> I think all the connections with all these people were very important. I had a very strong bond to Lynn and to Mark, also to other people...and they all came at different days so I never saw them all together. [All] the residents there had important connections with their primaries, like Lynn and Mark, but...there were lots of other staff people there [too]. I [felt supported by the Diabasis staff] I think Mark told me about his mother...

Specific Treatment Practices

In general, participants cited the "way" and its necessary environment as a general treatment approach that sharply differentiated Diabasis from medical model facilities. In addition, participants cited both specific practices (medication, ECT, seclusion) used at medical model facilities, but not used at Diabasis, and treatments available to residents at Diabasis but not available at medical model facilities. R. described the presence of a Rage Room at Diabasis:

> The other thing about Diabasis that I truly loved was they had a room designated as the "Rage Room," which was a small room. It was completely padded and covered with mattresses. There was no electricity—it was just dark, so when you first opened the door, you had to see if there was anybody in there. I liked that room a lot. Again, I felt very safe in there and I liked the idea...well, I guess I discovered that I could almost pound the fear out of myself and that there was some connection between fear and anger. I say that now, but at the time I don't know that I knew that. So, I liked that room a lot and I missed that when I left Diabasis. There aren't places like that. There are no places that you can go to scream, without people objecting or calling the police and getting you carted away.

A. also described the Rage Room, from the staff perspective:

> Inevitably, for almost everybody, clients that were there had very profound painful periods. There was a room that was called the Rage Room downstairs that people would go into which was basically just a little 8 x 10 room with mattresses all over it. The clients would just punch the walls. It was very safe, so they couldn't hurt themselves, and at the same time they could let it all hang out and scream and all that.

R. also described the Sand Tray Room, which made a classical Jungian therapeutic modality available at Diabasis:

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> The other thing that I liked in terms of the set up of Diabasis, they had another cubicle downstairs that was the big sand tray with little animals and things and discarded toys, and I liked that, too, because I could create my own little dioramas in the sand and things. I liked that a lot. It was definitely a universe unto itself.

Having these facilities available for residents demonstrated both the freedom allowed them and the respect for their inner life. Both the facilities and the attitudes that generated them contrasted dramatically with the medical model.

A Retrospective Critique of the Diabasis Model

While all the participants in this study believed that Diabasis was an important and necessary program, and that such programs should still exist, almost all would have changed something about the program. R. offered the least criticism of Diabasis. As I showed in an earlier section of this chapter, for her it was a "magical place," on a par with the other magical places in her life: her inner world as a child, her art studio, and Paris. While she stated that "not everything at Diabasis was totally pink-hued," she only implied a criticism of how the program worked when talking about clashes she occasionally had with particular people. As she said, "I didn't understand at the time and I still don't really understand what was going on."

Most of the other retrospective criticism of Diabasis fell into three general areas: (a) Diabasis was too vulnerable to its funding sources and unable to protect itself; (b) Diabasis could have been more effective in helping people if it had been less focused on a single explanation for and treatment of psychosis; and (c) Diabasis relied too much on uniformity, naivete, and "true believer" attitudes in its staff.

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Diabasis was too vulnerable to its funding sources and unable to protect itself

In response to a question about whether he believed that, in the future, a program such as Diabasis should cut all its ties with mental health services, John Perry answered affirmatively, remarking that

> insurance money isn't going to function in this kind of framework. It's not that kind of financing. And government programs aren't ever going to have a niche for this. In that kind of political setting and financial setting it's [too] subject to being killed off. And the motivation to participate in it, I think, is probably not a public one so much as quite private on the part of certain individuals who need to participate as subjects going through this. So, I think it would have more freedom outside the system. Malpractice would not be an issue. There would be no basis for legal suit, I think. And outside of the mental health system, you'd be free of the whole concept of disease and illness and medical condition—it would be a different concept.

Asked how he would try to fund such a program today, Perry ruled out the usual route of pursuing grants:

> Foundations don't give funding except for seed money for the first couple of years, maybe three, with the understanding that it would be self-supporting. If there is no promise of being self-supporting, you don't get the initial funding. So, there has to be some way of getting it underwritten, almost like public television. I think the best way to fund it would be to have scholarships for each bed . . . say six beds. You get wealthy people to take an interest in supporting one bed and give them a return gift in the form of a newsletter: what goes on in that bed; what their money is doing for them. So, it could be exciting that way, I think, for donors to see that they were really doing something for some particular people.

The Diabasis staff also remarked, to varying degrees, on the economic aspects of Diabasis. Both A. and B. referred to the serious issue of lack of funding for follow-up research, which made it impossible even for *them* to determine how successful treatment ultimately had been. B, noting that Diabasis only existed as a program for a brief time and offered very limited aftercare, said that

> it was so out of synch with the way the rest of society was looking...from the standpoint of economics. Economics can't be eliminated from the equation....one of the things that was happening then and that I am interested in now is the

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> economics of mental health care....the Community Mental Health funding would pay for ever-shorter segments of therapy, which basically made it impossible for people to establish a true therapeutic transference. I do believe that that is a very important piece of the healing process. So, we made the compromises with that.
>
> What is interesting now is that private insurance companies are following suit, and so the economic impact is sort of traveling up the class structure, from poor to middle-class, to people who used to feel as though some level of analysis was part of their expected mental health service. Forget it, it is no longer. But the first place it was felt was with poor people who could not establish a therapeutic relationship.

B. felt that, given the economics of the situation, the work done by the Diabasis staff was itself devalued. She pointed out that it

> was even devalued by the Board, in the way that they replaced the staff. I remember reading a proposal that one intern was writing to get a grant. In the proposal to the foundation, it said that there was a significant population that was so eager to be working in this setting that they would work for free. I thought, "This is a selling point! Coolie wages is a selling point!" And I was so offended, I went on about it, quite frankly. So, not just the meta-society, but even our support society—our Board, our funders—basically devalued the work that we were doing.

<u>Diabasis could have been less focused on a single explanation for and treatment of psychosis</u>

This finding reflects the finding (discussed in the earlier section of this chapter on the nature of psychosis) that psychosis is not a unitary phenomenon. All of the former staff I interviewed saw themselves as, at least in part, disagreeing with John Perry on this issue, even though, in his interview, Perry himself voiced a position similar to theirs. They felt that the model used at Diabasis was too narrow: J. stated emphatically that few people actually meet Perry's "criteria" for the Renewal Process: "I think it's really hard to get that kind of first break." In addition, all seem to believe that medication may be indicated in some cases of acute psychosis.

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B. noted that experiences subsequent to Diabasis, with people close to her, have influenced her feelings about psychosis and medication:

> The woman who was my roommate in college back in the '60s has a daughter who went through a schizophrenic break in her adolescence. I saw that family struggling with that experience, and I really had to question everything, as I watched the situation evolve. I guess now G. is in her late 20s and is an artist.
>
> I don't have the same feeling about the etiology of schizophrenia. The metaphor that I have used is: when a person has a cough it can be bronchitis, it can be tuberculosis, it can be as a result of smoking, it can be that they are in a congested room. And I think with madness there may be something like that at play. In some people it may be a psychosocial phenomenon. For some people it may be a biochemical phenomenon. I don't think we know enough about how it works.

B. also discussed changes in her understanding of depression as moving her away from rejecting biochemistry as a possible explanation for madness and towards believing that medication may sometimes be indicated. She described someone suffering from severe suicidal depression who

> had gone through about as much therapy as a person is likely to go through...one time [she] went through a fast, and came to such both a psychological and physical state...it was like hitting a brick wall...what was really clear was that what was going on was not just [psychological]. Since it was so sudden and had such an impact, [she] started taking Prozac. It took several weeks, almost a month, before there was any difference, and the difference was very subtle, and also very profound.

In retrospect. B. believes that Diabasis engaged in a certain amount of "tunnel vision." She said,

> If I were creating the world, I would do this in a way that each person's experience would be addressed individually. I guess it is useful to draw certain categories, but it seems to be the *only* way we go about it. It is hard to imagine that some states either defy categories, or bridge categories, and we don't know what to do. Maybe madness is both a blessing and a chemical imbalance, and something else as well, a virus as well. Maybe it is all three. There are fads in the way we think about those things that are really beyond what we ultimately can measure and know with any degree of certainty. So, we sort of grope for certainty, an explanation.

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B. was particularly concerned that the Diabasis model somehow overvalued those who were able to "go through" the Renewal Process and come out as productive members of society:

> It seems to me that there are people who live with a different reality and who do not cope effectively with this form of a social situation. At this point we pathologize that, and it seems to me rather than expecting that everybody can kind of "get with the program," it is more realistic to expect that *not* everybody can get with the program. As a society, how do we muster compassion, and how do we take care of the frail, and the chaotic? Do they all have to come to a point where they can get by and pass for one of us? Maybe not. And does that mean that as a society we have failed, as healers we have failed, or does it simply mean we do not know how to live with that degree of difference?
>
> And it does tax our compassion; it really taxes *my* compassion. [Chronic schizophrenics] who I encounter on the street, who frighten me, on one level I feel compassion for them, but on another level I jolly well want to avoid them. That is because it becomes very specific [and] individual. What can you do as a society to institutionalize compassion, to find a way of being caretakers, *collectively*? I don't know what form that could take, but I wish we could find some way because, at this point, it is so atomized, we aren't even looking for ways anymore. At least in the early '70s we were looking.

A. and B., the two staff members who felt profoundly affected by the suicides of the two clients who killed themselves after leaving the program, discussed whether a broader theory and practice might have prevented these tragedies. However, they came to no conclusions on this issue. A. pointed out that,

> on the aggregate, you could run a test to see, if you have relatively matched groups that come to one program or another, is there a higher suicide rate? I don't know. I think our suicide rate was probably pretty low, but it wasn't really a matched group. Would some people be less likely in one setting, and other people in another? That's the problem with these post mortems; you make the best decision [at the time] about their course of therapy. The argument is, would it have been safer to have medicated [my client who committed suicide]? The fact is, she ended up killing herself not in the program, but well out of it. Even had she been medicated while she was there, when she left there was no particular reason to medicate her. It wouldn't have made sense: she was relatively symptom-free, her ideation process seemed to be basically intact, and she had let go of the delusion around me. But all of those things are in the past, so who knows?

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John Perry's reflections on how he would have "done it differently" if he had another chance also refer back to the finding that, for participants in this study, psychosis is not a unitary phenomenon:

> Ideally, [a program] would be full of instruction...more self-instruction, in the ideas of art forms, symbolic forms, and imagery of various kinds, histories of various kinds, all made available so that people who wanted to go through the whole trip in a very profound way could keep educating themselves, much the way Jung did his....It would be like an overgrown retreat, but especially designed for this special kind of event....Almost like the new Epidaurus.[2]
>
> But I think you would have to subdivide it. One group of people who want to put it all into an art form and poetic expression or literature, some sort of expression of it, and that would be their chief focus. Other people are going to stay around a few months and really work therapeutically with this process and grow by it....[Jung] felt that artists and creative people live for their work, so to speak, and for the culture; therefore, they give the culture their gift, and fulfilling their own personal lives doesn't seem to be their prime motivation at all. For another kind of person, that would be the wrong thing to do, to externalize it at all. They should be brought back to fulfilling the individual....I must say I think there's something in that.

Perry particularly wanted any new alternative treatment center for acute psychosis also to have the capacity to foster prophetic visions purposefully:

> If it's laid out in a symbolic sort of surrounding, I could see it as sort of a launching pad for new myth form. There are prophets who aren't filling out their lives in the sense of getting married and making a place in the world and all that, they're solely dedicated in giving this gift to the people. So, in that sense, the prophetic function of art would be the culturally creative thing to do. I want a special place where they can do their thing and be protected from [pause] God knows

<u>Diabasis drew too much on uniformity, naivete, and "true believer" attitudes in its staff</u>

Another retrospective criticism of Diabasis on the part of staff reflected the discussion in an earlier section of this chapter, on the impact of the Diabasis experience. As I discussed above, all staff participants felt that their youthfulness at the time may

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[2] Epidaurus was the cult center of Asklepios, the healing god of Ancient Greece (Kerenyi, 1951).

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have been a necessary component that facilitated their ability to work in such a setting and with such clients. B. described this youthfulness itself, and the particular character it took on in the 1960s, as a potential problem:

> I came to San Francisco with a communal household, so that was also part of my searching and effort at that time, and it had that same sort of intense, self-absorbed, self-important...all those qualities. "This is the wave of the future. We've got a handle on the truth here." What goes with that is a kind of arrogance and smugness. I think that is one of the ways we compromised good judgment. If you are breaking new ground, you're figuring this is not some place where people have traveled before, so who knows what is okay and what is not okay.
>
> We were really young. I was one of the elders on the staff and I was in my late 20s. I think it [was just] naivete....certainly, I think the spirit in Diabasis came out of true generosity....It was a hell of a learning experience. And there are certainly dumber ways to go about those journeys.

B. also argued that, because the kind of work done at Diabasis is devalued by society as a whole, it

> relies on faith, true belief. Unless you are a religion, that is pretty [pause]. And part of the problem with trying to turn something like that *into* religion, into true belief, is that then you get hung-up on the contradictions between theory and reality, and if reality doesn't correspond to theory, then it is hard to figure out where to go next.
>
> In the interviews that I did in Eastern Europe, one of the things that was very interesting to me about the nature of freedom had to do with people's relationship with the truth. One of the impacts of communism, at least in Eastern Europe, is that it mediated between individuals and truth; the theory replaced reality. It is not a healthy way to live, you know, it really isn't.

She also criticized the uniformity of the Diabasis staff, even though she suspected that this uniformity might have contributed to its success:

> I think the thing was an admirable effort, and I think that it didn't recognize all of the multiple realities. It was a pretty white staff. It was a *very* white staff. It was a staff who had a certain access to a level of education, pretty self-selected. So, in that kind of situation, you *can* build in certain expectations and consensual kinds of decision-making, and I think that that is okay. But that was also a kind of naiveté.

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A. made a point similar to B.'s point about true belief, but he contrasted it with the true belief of those who cling to the medical model:

> People who want to start these programs are going to think that this is something that can really help a lot of people. Then they'll start narrowing it down. The Diabasis types will do *in extremis* just what the other people did on the other side, and define that, if anybody doesn't get helped by Diabasis, it is just too late in their process. They have already had too many breaks or something like that; just the opposite of the DSM medical model, which is "anybody helped by a Diabasis model really wasn't crazy."

A. also mentioned the issue of self-absorption as a problem. He commented that it "may have been our downfall. We were not focused out on the community, and therefore didn't protect ourselves politically. Perry really *was* in charge but wanted it to look like he wasn't."

In referring to the issue of staff being naive and unconscious of their own "dark side," A. expressed concern that there was a potential in programs like Diabasis for more serious problems. He remarked that too much emphasis on spirit and positive outcomes can create problems, if staff aren't aware of the residents' archetypal shadow projections on them.

Nevertheless, the various criticisms put forward by the staff participants constitute the smallest significant finding of this study. All agreed that programs offering the kind of treatment given at Diabasis should still exist. A. argued that this was so even if current social circumstances force such programs to operate without a "charter":

> As long as you have *some* decent controls and oversight, it cannot do any harm. As for getting meds into somebody sooner rather than later...except for numbing the immediate experience they are having, it really doesn't lead to long-term efficacy. And, if even a couple of people are actually spared getting routed into the chronic mental health system, which is not a lovely place to be, then it is worth it.

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Amplification of the Findings From Examination of the Diabasis Archives

I closely examined the Diabasis archives, including a program proposal, administrative notes, and 30 patient charts, in order to amplify the material in the participant narratives. Except when referring to letters from public persons, I will present this evidence in summary form, since I do not have permission, from either the residents or the staff involved, to use direct quotations.

In my more than 20 years as a therapist, working in a variety of clinical settings, I have been exposed to a variety of charting systems. The Diabasis charts particularly impressed me as being consistent with the program's emphasis on subjective experience. I also found the Diabasis charts remarkable for their lack of psychopathology jargon, which is typical in traditional clinical settings.

The charts consisted primarily of descriptions of contact (or lack of it) between the patient and various staff, confirming the finding that Diabasis' unique "way" of being with patients undergoing a psychotic episode was, for both staff and residents, the most salient aspect of the experience. Staff repeatedly described simply "being with" the particular resident, encouraging both personal contact and expression of content, and noted both the content and the affect expressed by the resident. Staff also noted their own feelings and impressions, often expressing how much they enjoyed contact with a resident or how interesting the person was. In many cases, cumulative staff notes recorded a progression from chaos to integration and the feeling of the resident that Diabasis was the "right place to be." Staff notes were not made only by primary therapists, but also

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included the comments of a variety of people, confirming the involvement of the staff as a whole with each individual resident.

Many of the staff notes contained indications of the times: many references by residents to their use of psychedelic drugs, participation in EST and other "human potential" programs, and sense of alienation from the larger culture. They also showed how Diabasis changed, as a result of pressure to admit residents who were undergoing "sub-acute" and chronic psychosis, or were primarily depressed, or what is now called "personality disordered." These particular residents did not demonstrate the kind of "activated psyches" that John Perry had sought out during his years before Diabasis. Many of them tended to withdraw from contact, or to engage in forms of manipulation, and staff often expressed concern about their appropriateness for the program.

Residents' charts showed evidence of the great variety of experiences present in psychotic episodes. Several narratives described residents and staff being involved in a psychodrama-like "acting out" of family issues raised by residents. Other narratives described residents' concerns with larger issues, both political (Nixon) and spiritual (Buddhism). One chart offers a story similar to that narrated by A., who described a client who killed herself after being discharged from the Diabasis follow-up day treatment program. As in A.'s description, the resident exhibited no symptoms of psychosis when discharged, but was depressed.

The charts included descriptions of clients being free to leave the house and engaging in a variety of daily activities in a home-like setting, as well as working in the Rage Room and using sand tray, painting, and drawing materials. Body work and massage, breath work, and the use of chanting and vocalization of sound are also described in the

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charts—additional modalities offered to the residents but not reported in the interview participants' narratives.

Administrative notes included discussions that make it clear that Diabasis was progressively forced to water down its mission. Near the end, it served almost as a kind of halfway house, in order to keep all its "beds" full.

Appended to the proposal for "Diabasis II"—as the program was called after it first lost its funding—were letters of support from a wide range of prominent people, including politicians such as San Francisco's Mayor at the time, George Moscone, and then-Supervisor Dianne Feinstein. Willie Brown, an Assemblyman at that time, wrote:

> The kind of treatment given by Diabasis to acutely schizophrenic young adults, within their community, should be supported. Since it is one of only two drug-free programs of this kind in the country, and for this reason appears to me to be both a treatment and research program, I believe federal as well as state aid should be contributed.

Many prominent figures in the fields of psychology and psychiatry, such as Rollo May, Stan Grof, Loren Mosher, and Joseph Berke (of the Laingian treatment centers in London), as well as prominent Jungian analysts Joseph Wheelwright, Edward Edinger, Michael Fordham, and J. Marvin Spiegelman, wrote letters of support. These letters uniformly expressed the conviction that a treatment center for acute psychosis, which did not use medication, was greatly needed. Wheelwright's letter also expressed the belief that "Diabasis actualizes some of Jung's most important discoveries and, furthermore, they work."

Gregory Bateson, in one of the most eloquent of these letters, wrote:

> John Perry tells me that his little inpatient operation, Diabasis, is in danger of loss of funds....Diabasis is one of a very few institutions across the country which carry responsibility for advancing our understanding of psychiatric phenomena....Psychiatry perhaps more than any other branch of medicine is

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subject to the temptations of mass production. The economic pressures, the frequency of mental illness, and the small number of specialists, together with the often chronic nature of the pathology combine to push the profession into oversimplified answers to problems which are almost as complex as any which the human spirit can present. In just a few places and necessarily on a small scale, this complexity is being faced. I would argue that those places are curiously precious, not only for the few patients who are lucky enough to pass through them, but also precious to the whole psychiatric profession and the wider field of helping skills.

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CHAPTER IV

DISCUSSION

This qualitative study explored the experiences of going through a psychotic process and of working as a staff person at Diabasis, a Jungian medication-free residential treatment center for early episode acute psychosis that operated in San Francisco in the 1970s. It investigated the origin and evolution of the Diabasis treatment philosophy and the continuing effect of the Diabasis experience on both residents and staff. Using in-depth semi-structured interviews with participants in the Diabasis program, review of the Diabasis archives, and examination of unpublished manuscripts, it explicated the treatment approach, as well as the history, of the program.

The results showed that the life and treatment philosophy of Diabasis founder John Perry, as well as the social milieu of the 1960s and 1970s, contributed necessary conditions for the existence of Diabasis and that its treatment approach hinged upon a particular "way" of being with residents. This "way" consisted of a unique Jungian style, evolved by Perry, that used a Taoist "active receptivity" to engage the archetypes of the collective unconscious as they expressed their powerful drama of affect and image on the stage of the Self. Participants' beliefs regarding the nature of psychosis tended to converge around certain themes: (a) that psychosis is not a unitary phenomenon; (b) that it can be, for at least some people, both a purposive developmental process and an experience with strong transpersonal and archetypal elements; and (c) that, given the right kind of support, such people can come through the experience "healed." Participants were strongly critical of the medical model, which Diabasis sought to supplant, but also expressed some retrospective criticisms of Diabasis itself. All felt that Diabasis continues to have a profound influence on their lives.

I feel that the heart (in both senses) of this study is the eloquent response of the resident to the many facets of the question, "What was it like to go through a psychotic

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process at Diabasis?" I initially intended to base the study entirely on the subjective accounts of several residents. However, after an extensive search for former residents, I was only able to locate one potential participant. Reluctantly, I accepted that I needed to change my design and expand the scope of my questions so that the focus of my research became an historical case study of Diabasis. I included the experience of the staff and of John Perry, while keeping the richly informative account of the one resident as my study's centerpiece.

While I had expected much of what I discovered, given my own experience of working in an alternative treatment program for acute psychosis, two of my findings particularly surprised me. I was surprised to discover that the Diabasis "way" of relating still strongly affected its former staff, both in their relationship styles and in their views of society. And, given the family therapy orientation of the program in which I had worked, I was impressed by the efficacy of treatment *solely* employing the Diabasis "way." As a result of this study, I have concluded that the majority of people who can traverse a psychotic process successfully can do so without the intensive family therapy interventions used at I-Ward.

In this chapter, I will explore some of the clinical, social, and theoretical implications of my study, as well as practical applications and directions for further research. As I stated in my introductory chapter, I hope that my work will contribute to increased clinical understanding both of psychosis itself and of possible alternatives to current biopsychiatric treatment.

Clinical, Social, and Theoretical Implications

Implications of the "Way"

The results of the study generally support both Jung's and Perry's theories about psychosis, in addition to highlighting certain areas of Perry's work not explored by other

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researchers. The central finding that emerged was the importance of the Diabasis "way" in enabling residents to move through the psychotic process and emerge healed.

This finding answers the core question buried in the explicit questions I asked when beginning this study: does just "being with" psychotic clients in a particular way constitute both the necessary and the sufficient conditions for them to heal? Having explored this question of the necessary and sufficient conditions for so many years, I now am convinced that "being with," especially as exemplified in Perry's "way," is almost always the absolutely necessary condition for the healing of psychosis, and sometimes is fully sufficient as well. The rare person may be able to "make it through" without this kind of attention and support. Most clients, however, need an entire environment, such as that provided by Diabasis, and some may need years of this kind of therapeutic support after their initial psychotic break. Nevertheless, although the healing process may be enhanced and facilitated by supportive treatments, I believe it is "being with" that heals.

I know, from my work on I-Ward, as well as from descriptions of non-Jungian treatment programs, that people heal without the uniquely Jungian and Taoist "way" practiced at Diabasis. However, both my clinical experience and R.'s description of her process, lead me to believe that, at least for some people, the "way" offers a particular depth of healing not available in other settings. R. spoke, over and over, about how Diabasis emphasized the "value of the inner world," and how much she needed that. She was explicitly pointing to the value the Diabasis "way" placed on symbolic and archetypal experience. Her symbolic experience was not merely viewed as expressing conflicts in her "personal unconscious," to use the Jungian term. Instead, her therapists received it as expressing universal contents and as potentially visionary—not as merely "delusional," but also as truly "religious." I doubt that her process would have had the same outcome, or as positive an outcome, in a program without this orientation.

Since Perry was a member of my original dissertation committee, he had to sign off on each chapter of my study as I completed it. When I sent him my results chapter

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for review in the spring of 1998, I was apprehensive that he would object to my characterization of the Diabasis—that is, his—approach as the "way" of treating psychosis. I feared he would see it as yet another kind of New Age pretentiousness. He didn't. Instead, he returned the chapter with his approval (and, in his inimical style, with line by line typographical and spelling corrections). Even though Perry had no penchant for self-promotion, he too believed that his "way" comprises both the necessary and sufficient conditions for the treatment of acute psychosis and is an extremely valuable discovery. A year earlier, in an interview in *Psychological Perspectives* (Henderson & Henderson, 1997), Perry stated that Diabasis "gave me a real confirmation of what Jung was talking about but also opened me to things beyond what he had a chance to see himself—I wish he had a chance to see what we saw. He had already died by the time we conceived of Diabasis..." (p. 55).

Most therapists of my generation remember a remarkable training film that showed Fritz Perls, Albert Ellis, and Carl Rogers, each doing a demonstration session with a client named Gloria. In comparison to Perls' emotional confrontation and Ellis's rational problem solving, Rogers' style was that of a kindly father, intent on reflecting back the client's statements in the least intrusive and seemingly most receptive manner possible. As a novice therapist, it seemed to me that Perry and Rogers shared many of the same "client centered" values (congruence, unconditional positive regard, and so on). Rogers believed his approach incorporated those attributes therapists must embody in order to assure that they would facilitate positive change. In essence, he was putting forth a "way" that he claimed comprised both the necessary and sufficient conditions for the treatment of clients.

Curious about these similarities, I asked Perry how his style of therapy differed from that of Rogers. Perry responded by saying that Rogers had tried his client-centered approach with chronically psychotic clients, without much success, and had never been able to work with acute, first break psychosis. Perry believed this was because Rogers'

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style was too formulaic and "busy," rather than truly receptive of the psychotic process. Perry described his style, in contrast, as "waiting in attendance on the psyche" and allowing it to "point to and lead the direction" of the work.

Receptive. That is the one word that always comes to mind when I remember Perry's work and style. Before 1984, when Perry and I began collaborating in our attempts to develop replacements for Diabasis and I-Ward, I had been in Jungian analysis with him for 4 years. After my analysis, he also served as my main clinical supervisor (during my Ph.D. internships at CIIS), helping me to understand, even more deeply, what it means for a therapist to be receptive.

But how *do* we understand receptiveness? As therapists, can we know "scientifically" how receptiveness feels—whether we are being receptive ourselves or receiving it from another? What does it mean to postulate being receptive or congruent, or showing unconditional positive regard, as goals? As therapists, we try to understand, intellectually and intuitively, how these subjective states feel. But can we objectively measure them in ourselves or measure their supposed therapeutic effect on others? All these questions came to mind as I tried to formulate my own definition of what I have called the Diabasis "way."

It's work—hard and often frightening work—to be with, and responsible for the well being of, a person who is in the hyper-aroused state of acute psychosis. It's so much easier to medicate them, shut them up, turn off the incredible psychic sensitivity that makes *us* feel vulnerable and exposed, as well as the uncanny, transpersonal depth that fills any room they enter. The only alternative is to develop some kind of internal "way" of being with them, an inner zone you practice from and in. In doing so, you become, as did Perry, Jung, Laing, Mosher, Mayerson, and others, a kind of therapeutic internal martial or shamanic artist. And, in designing a milieu, you externalize this art.

It's not really ineffable, this inner experience. I suspect that most first-year therapy interns have had moments of it in their training. Maybe an aptitude for this

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experience is what initially called most of us into this vocation. As fledgling caretakers and therapists, we probably had been doing some version of this work in our own families since we were children!

When we are with others and really know, in the moment, that we have helped them to move and heal, we are practicing an *art*. I believe we love this work because, in those (perhaps rare) moments, we lose ourselves in the creative act of psychotherapy in the same way that painters and musicians lose themselves when the artistic *daemon* or creative impulse possesses and inspires them.

Perry's re-visioning of the Jungian concept of the Self is very important to the development of the Diabasis "way" as well. Throughout his work on psychosis, he enlarged on and clarified Jung's vision of the Self, demonstrating that it was not simply the teleological endpoint of psychological growth. It was, as Perry called it, the archetype of the Center, whose existence must be posited if psychosis is purposive. He viewed it as both the source of *agape* (societal love) and the always potentially vacant but never actually empty stage upon and within which psychosis and all other integrative experiences of the psyche are acted out. He understood the powerful affects and images that emerge as archetypes from the collective unconscious as the material that Diabasis practitioners needed to elicit, welcome, and help residents integrate.

Perry also saw all archetypal material as connected to "real world" relationships and situations. Residents at Diabasis integrated their psychotic archetypal turmoil through renewing their outer worlds, as their symbolic and affective process was received and ran its course.

Perry's experiences in China imparted a strong Taoist and Buddhist quality to his neo-Jungianism; this might have made him more allowing of and receptive to psychotic material and experience than any Jungian before or since. Although Jung too was strongly influenced by Taoism (Rosen, 1996), I would contend that Perry was more allowing in relation to psychosis than was Jung himself. Perry noted that, despite Jung's own work

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with psychosis, he often urged other analysts to curtail analysis if clients had dreams that might indicate a latent or incipient psychosis. Perry, in contrast, believed that the psyche was able to handle such deep archetypal content if it was received properly by the practitioner.

Perry's "way" was also more Eastern, and specifically more Chinese, than the methods of Laing and those who were influenced by him. Obviously, my calling Perry's method the "way" suggests a relationship to "the Way"—the usual translation of "Tao"—of Taoism; given his background, this similarity is not coincidental. The "way" that Perry promoted is receptive but not passive. In practicing it, therapists must continue to center themselves in a very allowing mode of being with clients. Though deeply engaged, involved, and even active in response to the client's process, the therapist remains receptive in a particular manner.

This manner brings to mind the paradoxical Taoist notion of *wu wei*. Inadequately translated as "action through non-action," *wu wei* has a powerful effect on others through its harmony with the underlying rhythm of nature: the watercourse movement of Tao. Blofeld (1978) wrote that, "reduced to its essentials, *wu wei* is "knowing how to value the teaching without words, to cultivate the art of leaving well alone." (p.17). Rosen (1996) quotes Jung as recommending practicing "*wu wei* (action through non-action)...let things happen" as a way of outgrowing problems; he also describes Jung's own embodying of *wu wei,* during his final years, calling it "being spontaneously reborn in spirit" (p. 159). As this indicates, such action comes out of a particular and allowing harmony with the Tao, the "spirit" that underlies everything.

In my own images of this model of therapy, the therapist acts as an open vessel, or as two cupped hands, into which clients can pour their process and have it received and held. The client needs this other person—a therapist with an intact ego—to act as a vessel, or holding tank, for affect, images, and powerful transpersonal energy. The client's Self, or archetype of the Center, seems remarkably able to constellate in response to this

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necessary "other" and images of mandalas, and other containing geometric forms, begin to emerge in the client's dreams and symbolic expressions, such as painting. It is a rare psychotic person who does not need another person to facilitate this process.

Varieties of Psychotic Experience

In Jung's (1965) autobiography, *Memories, Dreams, Reflections*, he recounted his own immersion in the depths of the psyche in the chapter titled "Confrontation with the Unconscious." It is evident, from his own report, that he went through a process that would qualify as psychotic in today's typology, or even in the working diagnostic model of his own time. Although he had contact with and received support from both his wife, Emma Jung, and his lover, Toni Wolff, he does not credit either of them with being a crucial human "other," or therapist, of the kind I have described as being necessary for healing in the vast majority of cases involving psychosis. Based on my reading and clinical experience, I believe that this ability—to go through a psychotic process essentially alone and to emerge from it a more highly functioning person—is extremely rare. It may be, in fact, a kind of genius: a genius for accessing those inner archetypal mediators who helped Jung through his initiatory ordeal. These same mediators are described in cross-cultural accounts of shamanic initiatory ordeals, but Jung had no cultural context to frame his experience.

Perry himself, in the interviews I conducted, suggested that there might be several different types of psychotic processes. There are some psychoses, such as those experienced by Jung and R., the resident I interviewed, that initiate the person into a shamanic or artistic vocation. Almost all such people require, at least during the acute phase, the containing presence of others who provide a "way" that prevents them from becoming lost in the unconscious and condemned to a lifelong "chronic" reliance on others—and on medication. Perry believed that such clients are usually floridly psychotic

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at the outset. Because they are producing considerable inner symbolic content, he believed that they could benefit most from a program like Diabasis.

Perry felt that "flat" clients had a less hopeful prognosis. In my experience, these clients can also be healed by the "way," but working with them requires a long-term commitment. One of these client, whom I first worked with on I-Ward, when he was 18, required 10 years of intensive follow-up therapy with me. His initial acute psychotic break produced almost no symbolic imagery or delusional material and did not resolve itself in the expected "40 days in the wilderness" (actually three months in the Diabasis model). He had many of the "negative" symptoms Perry associated with a poor prognosis and, during our years of therapy, experienced repeated decompensations. However, these decompensations happened as he worked through each layer of buried affect and images, brought forth mainly through his increasingly active, archetypal dream life. He can now experience anger, fear, desire, sadness, joy, loneliness, and love, without becoming psychotic. He is married and functioning fully in the work world. I believe he is fortunate that my clinical supervisors during those many years were John Perry, David Lukoff, and Tanya Wilkinson. They supported my doing dream work with a "Schizophrenic, Disorganized Type" whose inner process was emerging to heal him, rather than demanding that I practice within the parameters of conventional wisdom and treatment.

Psychosis, Mythology, and Politics

If Perry had not discovered an innovative way of succeeding with psychotic clients, he would never have written his seminal book, *The Self in Psychotic Process*—nor would Jung have written his "Forward" to it. While the book was about clinical practice, it downplayed Perry's inner stance and experience as a therapist in favor of providing evidence of how psychosis "worked" in his Jungian based theory. Sometimes, innovations in treatment, when documented in book form (and especially when the author is relatively

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modest) get presented as largely theoretical justifications, or even apologies, for trying a new approach, rather than as bold declarations of success or as challenges to the status quo.

Perry's work with psychosis, which he began in the late 1940s, was every bit as bold in its scope and as challenging to the medical model as Laing's work, which began in the 1950s. In fact, Laing had read *The Self in Psychotic Process* before he published *The Divided Self* in 1959, since it was included in his bibliography. However, Perry's work realized a fraction of the popular and clinical familiarity of Laing's. This may have been because Perry was less interested in, or skilled at, self-promotion and also because the time wasn't necessarily ripe, as it was by the early 1960s, when Laing's book began to circulate. By all reports, however, they both had a similar receptivity to psychotic clients. Without it, both their theories of therapy would have been proven ineffective by their own examples of failed treatment.

One aspect of Perry's work, which I have not previously discussed in this study, involved a central finding of his own investigation of psychosis: its relationship to the myth of the Royal Father (Perry, 1953; 1970; 1974; 1976). Perry elaborated on the myth of the Sacred Kingship, which first emerged at the dawn of the Bronze Age, as the archetypal form he observed in the psychotic Renewal Process experienced by his clients in the 1950s and 1960s. Eliade's (1954) *Myth of the Eternal Return* had inspired Perry to believe that what he was observing replicated the mythic death and rebirth of the "Father/King" of the ancient city-state. Perry fastened onto this myth as Freud had fastened onto the myth of Oedipus. He believed the elaborate and regenerative Sacred Kingship rites offered a ground plan that explained the very similar—and powerfully archetypal—repetitive processes and motifs of polarization, death and rebirth, and so on, that he saw occur again and again with his psychotic clients.

However, none of the participants in my study referred to this major emphasis of Perry's work when discussing Diabasis. To this date, Perry's mythic correlation of

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Bronze Age City-State kingship rituals with 20th century psychotic symbolic content seems not to have been fully understood, much less adopted by his Jungian colleagues, and has essentially been ignored by the broader alternative treatment movement.

Psychoanalytic theory has been sometimes criticized for its "developmental tilt"—the tendency to reduce the causation of all adult behavior to an unconscious expression of disturbances in childhood object relations. This tendency is rooted in Freud's adoption of the Oedipus myth as an explanatory construct for unresolved sexual and aggressive urges. I suspect that Perry's theory suffers from the Jungian version of this tendency—a kind of "archetypal tilt." (Jungians—of whom I am one—tend to explain or justify every experience in the psyche through reference to an earlier *mythic* form.) Nevertheless, I wonder if Perry's theory might have gained the status he believed it deserved if, over the past 20 years, he had remained one of the respected founders and elders of the San Francisco Jung Institute, rather than having been expelled shortly after Diabasis finally closed.

Personally, I believe there is some validity to Perry's sense that 20th century psychosis is connected to the myth of the Royal Father, but that he stopped short in his explanation. I think he missed another possibility in his own clinical accounts, where he described, time and again, that the resolution of a patient's psychotic process did not involve the emergence of values associated with the "rebirth" of an ongoing (albeit reformed) royal patriarchal system. Instead, the psychoses he discussed (and those I observed on I-Ward) repeatedly involved imagery associated with the true death of the Royal Father: the revolutionary assertion of post-patriarchal, feminist values and governance. This "inner revolution" resembles a kind of post-Jungian New Testament, where rebirth and regeneration cause an eclipse of the City-State in favor of a new focus on rural values and a re-animation of natural forces and elements. It correlates with our new view of the earth from space, as a fragile home in the shape of a mandala. Here values of the heart and hearth must now by necessity emerge for our continued survival as a

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species, but here also individual freedom allows for exploration of previously unimagined depths of experience.

Just before his death in October 1998, Perry told me that he had rarely been privy to the expressions of the deep, visionary psyche, as manifested in the psychotic process, since the days of Diabasis. As a result, he regretted that he "didn't really know what was brewing" in the psyche, as compared to when he "had that window on it earlier." As a Jungian myself, I have pondered this statement ever since.

In the Jungian framework, therapists can view the products of the unconscious by looking through the "windows" provided by dreams or visions (their own or their clients'), by active imagination, and by the "waking artifacts" produced in the psychotic process. When Perry told me that he no longer had the "window" of psychosis, he meant that dreams and active imagination weren't enough! The *prima materia* provided by the psychotic process was not available to him anymore, hence he could "no longer speak for" what the psyche was trying to express in all its fullness. If he is right, neither can the rest of us, because none of us are working with the psychotic process as he did at Diabasis, given that such a program no longer exists.

As Perry often said, our culture *needs* the window that prophets, visionaries, shamans, and mad people bring us. Although Perry did not romanticize the incredible pain and terror of the experience, he continued to assert that madness is potentially as valuable to a culture as other prophetic, visionary, and shamanic experiences. But we can only receive this value if we honor madness, listening and relating to it with care. If we do, we may find that it is the precious material of the next myth form, emerging to shape our evolving inner and outer lives.

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Practical Applications and Political Correlates

As I noted earlier, as of this date (February 2002), I do not know of any residential alternative treatment programs for early episode acute psychosis operating in the United States. Given the current emphasis on producing outcome studies and measurable results in order to "sell" any idea, this is not surprising. Nevertheless, over the last few years, I have been able to use material from the literature review and results of this study to support both a planning process and a political effort directed towards developing a Diabasis-style residential program in the San Francisco Bay Area. The findings of my dissertation fortified the initial working group involved in this project in their resolve to start up a new alternative treatment program.

Several years ago, I began to organize meetings at John Perry's house, inviting mental health administrators, researchers, political activists, clinicians, and writers committed to the alternative treatment model. We came up with three tentative scenarios: a government funded, multi-bed "diversion" program; a smaller (four-to-six bed) program funded by a foundation grant or a wealthy private donor; or a small program where four to six sponsors would each fund a single bed. Surprisingly, the difficult public sector, which has seemed totally dominated by the medical model for at least two decades, has born fruit first.

In August 1999, the Board of Supervisors in the county mental health system where I work voted to allocate $900,000 to fund a 16-bed residential program, including some "first break beds," as a pilot project. In September 1999, I was invited to attend a planning retreat for this project, with the County Mental Health Director and seven other mental health administrators. The Director asked me to speak to this group regarding my research on and experience with alternative treatment, as well as regarding the "vision" of clients being served in a residential treatment program not based on the medical model. As

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of February 2002, this project is still under development; a set back resulted from pressure on local politicians by a neighborhood NIMBY ("Not In My Back Yard") group, which was able to prevent the initially planned residence from opening.

As the findings of my study demonstrate, the social milieu had a decisive influence on Perry's ability to create Diabasis. I believe that, despite "NIMBYism," there is again a cultural receptiveness to alternative treatment, but for quite different reasons from those operating in the 1970s.

One of the most crucial factors is that people of the "sixties generation" have finally moved into positions of power and influence. Some of these individuals are providers who led or worked in the alternative treatment movement in the 1960s and 1970s. Because they have stayed in public sector mental health systems long enough to become senior staff, their authority within the hierarchy now enables them to act as catalysts for a revival of this movement.

In addition to the current position of members of the sixties generation within the mental health system, they now hold positions of considerable influence within the broader field of health care. The burgeoning alternative health movement contributes greatly to a growing climate of receptivity to alternative treatment of psychosis. Led by physicians like Andrew Weil, this movement has reached a kind of critical mass. Health consumers in general now commonly question their doctors' treatment, as well as the assumption that the Western medical model is the last word on what kind of treatment may best help them.

These consumers have been exposed to a holistic model, which emphasizes "healing" and prevention rather than allopathic medicine's pharmaceutical "magic bullets." As a result, they turn to remedies and systems such as Chinese medicine (acupuncture and herbs), European herbal remedies (such as Saint John's Wort for depression), and self-regulation strategies such as Tai Chi, hypnosis, cognitive therapy, and guided imagery. Demands for such alternative and self-directed treatments, and support for

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alternative paradigms, fuel a movement that increasingly undermines the prestige of those wed to the medical model.

In fact, Weil (1995) used psychiatry itself as the exemplar of how far "medicine in this century has moved toward a materialistic and mechanistic view of human beings" and away from an emphasis on how mind and spirit affect health:

> ...once a noble enterprise—the word ["psychiatry"]...comes from Greek roots meaning "soul doctor"—[it is] now reduced to a branch of pharmaceutical science. The field is dominated completely by a biomedical model that views all disturbed mentation as a result of disturbed brain chemistry and so offers us drugs as the only treatments worth using. (p. 24)

Momentum for alternative treatment of psychosis also now arises from the growing strength of the movement of psychiatric survivors and consumers, sometimes called the "madness network," which maintains that complete recovery from "mental illness" is possible. This movement "turned 30" (Oaks, 2000a, p.2) two years ago, according to Support Coalition International (SCI), which publishes its most long-lived periodical, (formerly *Dendron*, now *MindFreedom Journal*). In 1999, the county where I work sponsored a conference, attended by 500 people, on this "recovery model." Daniel Fisher, a psychiatrist who has recovered from "schizophrenia," spoke about Perry's work at Diabasis as an example of what is needed now for consumers. (As I noted in the introduction to this study, Fisher is founder and co-director of the National Empowerment Center [NEC], which promotes the recovery model through publications and public appearances.) My county's mental health administration has since adopted this progressive (some would say radical) version of the recovery model: a public county mental health document states that "full recovery from Bi-Polar Disorder and Schizophrenia is possible."

In 2001, David Lukoff, Carol Patterson (of the NEC's new West Coast Office), and I did a presentation and workshop at another recovery conference held in my county; this conference attracted 750 participants. In addition, the county has recently convened

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an Anti-Stigma Task Force, on which I serve, which is co-chaired by two consumers. One, who was diagnosed with Bi-Polar Disorder, has "completely recovered" and has neither taken medication nor been in therapy for the last five years. The other, a survivor of repeated ECT treatments for "schizophrenia," is both a leader in the international consumer/survivor movement and a paid advisor to the County Mental Health Director.

Because of this increasingly vocal "culture" of mental health consumers and psychiatric survivors, as well as ever more discriminating health care consumers, public attitudes towards the massive use of neuroleptics to suppress psychotic symptoms may be changing. More people are questioning whether "chronic schizophrenia" is actually an artifact of such treatment. Popular magazines are now publishing articles critical of the medical model: a recent issue of *GQ* (with rapper "Puff Daddy" on the cover) featured an article on the work of David Lukoff, a "new breed of psychiatrist [*sic*]" (Shorto, 1999). Two months later, an issue of *Psychology Today* (with Madonna on the cover) published an attack on biopsychiatry by Loren Mosher (1999). Mosher discussed the history of Soteria, the attempts of "friends of the drug industry" (including NAMI and the local psychiatric society) to remove him from a recent job, and an analysis of the economic interests fueling these "friends." Mosher, who is on the Board of Directors of SCI, also announced that he had finally resigned from the American Psychiatric Association, because he wants "no part in it anymore" (p. 80).

Although medication is still the treatment of choice in contemporary psychiatry, even some psychotherapists are beginning to see it as a much less sophisticated response than it once appeared to be. I was recently asked to speak on a panel and lead two workshops at a conference on "Spirituality in Mental Health and Mental Illness," co-sponsored by the Spiritual Emergence Network (SEN), San Francisco County Mental Health, and my graduate school (CIIS). I received strongly positive audience feedback when I asserted that *all* psychosis is a "spiritual emergency" —that, as a Jungian, I *define* psychosis as an expression of archetypal transpersonal forces. Subsequently, I was

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invited by CIIS to present a day-long Mandatory Continuing Education workshop on my work, entitled "Alternative Treatment of Psychosis," in May 2002.

In addition, although they have been slow to realize this, HMOs and county mental health systems, under managed care, face a crippling fiscal future if most people who have an initial psychotic break stay in the system indefinitely as "Severely and Persistently Mentally Ill." Repeated acute and custodial care for such people could easily extend to 20 to 30 years and, if life-long, to 50 plus years. As a result, the financial realities and politics of managed care are now fueling a search for alternatives to acute hospital care, which costs upwards of $1,000 per day.

Ironically, as a result of my input, mental health administrators in my county, exploring every possible strategy to reduce their fiscal liability for such consumers, finally seriously reviewed the Agnews Project study. One administrator admitted that, over the last few years, not a single patient who appeared at the county hospital with an acute psychotic episode was diagnosed as Schizophreniform; the usual diagnosis was Schizophrenia, however recently the symptoms had appeared. In other words, no time was taken to determine if their "schizophreniform" symptoms would convert to Schizophrenia after six months duration, as required by the DSM-IV. At the meetings at Perry's, the former Adult Services Program Chief from my county was quick to point out that fiscal imperatives alone would cause him to support a 1990s style "diversion program" modeled on Diabasis. He even wondered if we could "take it on the road"—get private HMOs to contract with us to keep down their front-end acute costs.

Unfortunately, progressive positions such as these, while bolstered by the consumer/survivor movement, have also generated an intense backlash from the politically powerful association of "family members," the National Alliance for the Mentally Ill (NAMI). In concert with the "partnership" the American Psychiatric Association admitted it has formed with the pharmaceutical corporations (Breggin, 1991), NAMI operates as the third member of what Mosher (1999) has callled an "unholy alliance." It

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has long dominated the political discourse regarding mental health at both national and local levels and bolsters its arguments with the latest brain and PET scan research put forth by biopsychiatry to support the medical model. NAMI members distribute posters stating that "Schizophrenia Is A Brain Disease" and disparagingly refer to non-SPMI clients—including those with "problems in living" such as suicidal depression, post-traumatic stress disorder (PTSD), and severe character disorders—as the "worried well." Some NAMI members also insist that members of the consumer/survivor movement do not represent "our children."[3]

NAMI is largely funded by the pharmaceutical industry, to the tune of "more than $12 thousand a day"; this is now a matter of public record, since *Mother Jones* published an expose (Silverstein, 1999) rooted in the arguments long made by Support Coalition International; Oaks (2001) noted that Project Censored named the NAMI-pharmaceutical industry connection one of its "Top Ten Under Reported Stories of 2001".(p. 26).

NAMI is currently sponsoring an aggressive campaign to pass legislation in all 50 states that would roll back patients' rights. They call this Court-Ordered Outpatient Treatment and, in their own literature, make a case for "caring coercion" in cases of "poor medication compliance." (Yannello, 2001, p. 14). Consumer advocates call this program Involuntary Outpatient Commitment (IOC). They point out that NAMI's Program of Assertive Community Treatment (PACT; see NAMI, n.d.) also emphasizes "medication compliance." In some areas, PACT acts as "the enforcement arm of Involuntary Outpatient Commitment, [sending workers to] visit clients' homes daily to stand and watch as clients take their daily dose—involuntarily—in their own living room" (b, 2000, pp. 14-15). Simple refusal of a consumer to take medication would become grounds for involuntary hospitalization; this has long been allowed only when individuals are

[3] These expressions have been used repeatedly by many NAMI members with whom I have had personal contact for over a decade.

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determined, by professional assessment, to be dangerous to self or others, or unable to provide for their own basic needs.

NAMI passionately opposes the implications of the consumer-generated recovery model, which undermines the "brain disease," "once ill, always ill" doctrine of bio-psychiatry. In my county, an intense political struggle seems to be in the offing. Nevertheless, NAMI still has enough power to convince clinic supervisors to make their latest brochure available in children's clinics. Entitled *Parent and Teachers as Allies: Recognizing Early-onset Mental Illness in Children and Adolescents* (Burland, 2001), this brochure ("funded by an unrestricted educational grant from ALZA Pharmaceuticals") attempts to add the school system to the "unholy alliance" described by Mosher (1999). It argues that "early onset brain disorders are a biological given" and complains that

> unhappily, because brain disorders in children are not well recognized, children with mental illnesses are more likely to be diverted into counseling than medical treatment. Any child with *persistent* behavioral difficulties should have a psychiatric evaluation....Parents and teachers must watch for early signs of severity and disability so they can speed the referral to a qualified psychiatrist. (p. 4)

As a public sector psychotherapist, I find this frighteningly reminiscent of what happened in adult services, where the biopsychiatric alliance was eventually allowed to dictate the "standard of care," which eliminated therapy for psychotic—and all other—clients. Now only medication and case management can be provided, and these only for those clients defined as having a "brain disorder." I believe this is the logical outcome of the medical model.

Implications for Future Research

I believe that my findings support the necessity for further research in the general area of alternative treatment of psychosis. For many years, substantial clinical anecdotal evidence has pointed to the efficacy of the treatment carried out at Diabasis, as well as at programs such as Kingsley Hall, Burch House, and I-Ward. Unfortunately, none of these

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programs had a quantitative or qualitative research component funded as part of their design. This shortcoming has created a major problem for substantiating and rating their true efficacy. In the U.S., only Soteria and Emanon, the Bay Area's Laingian alternative treatment centers founded by Loren Mosher, did outcome research as part of their program. Mosher's (1992, 1994, 1999) work has demonstrated a positive outcome similar to the Agnews Project: that residents of a non-traditional program do as well, if not better than, those treated with medication as the main intervention.

Over the last decade, my regret over this lack of supportive research has grown, influenced by my experience under managed care, with its emphasis on accountability regarding efficacy and outcome measurement. Private and public HMO's, managed care systems, and insurance companies now rigorously demand measurable results for every treatment dollar expended and can be most easily influenced by "hard data" demonstrating that alternative treatment saves money. If all the alternative treatment programs like Diabasis had documented their results, the cumulative weight of these reports might have enabled alternative treatment to remain part of some mental health systems, rather than essentially dying out—now to be resurrected with much effort.

The implications for future research which I derive from this study point to the importance of follow-up studies on former, existing, and future alternative treatment programs as being crucial to the future funding of alternative treatment. Despite the necessarily qualitative nature of my study, it has already influenced priorities in the county where I work. I believe that a large-scale interview project could have even more impact on practicing clinicians. This might be especially true of one that focused on practitioners who have worked in alternative treatment programs and who are now licensed therapists.

While the lack of a research component in earlier alternative programs, such as I-Ward, would limit follow-up studies to qualitative methodologies, this, fortunately, is not true for Soteria. John Bola (1998) who presented his work-in-progress to a meeting at

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Perry's in 1998, has done follow-up research on the earlier Soteria studies. Supported by an NIMH grant, he examined the efficacy of the use or non-use of medication with psychotic clients at Soteria. Because of his sophisticated quantitative methodology, his work is likely to be influential and may encourage NIMH to fund further studies on alternative treatment. The advancement of science itself requires that we intelligently question the dominate "brain disorder" paradigm that now regulates "normal science" (Kuhn, 1996) at major research centers, such as UCLA and Harvard. A dominant paradigm allows researchers to dismiss what Kuhn called the "incommensurable" evidence, such as that presented by Bola's and my studies, which may turn out to be the foundation of the next "scientific revolution" in psychology.

I understand that there are contradictions between a non-objectifying treatment program like Diabasis or I-Ward, where residents were not diagnosed or told they had a mental disorder, and quantitative research, which is by nature objectifying. Nevertheless, I believe that, particularly given the current climate, some kind of compromise needs to be reached if such a program is to be tried again now in the public sector. We need a blend of quantitative and qualitative research designs that measure outcome in a non-intrusive way and also allow for the kind of findings (such as this study's finding on the Diabasis "way") that can emerge using qualitative methods. The central question I pose for future researchers is: What kind of research method could have been used with R., the resident at Diabasis, that would not have interfered with her healing process or have made her feel devalued or objectified?

Given these constraints, I believe that all future and existing alternative treatment programs, including the Spiritual Emergence Network (SEN), which does not (yet) offer residential treatment, should have some kind of research component. One way to foster this is to attract the interest of graduate students like myself and involve them in research projects. (In the case of SEN, this has now been facilitated by its move to CIIS.)

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I also believe that alternative programs need to incorporate the advances of the last 20 years, where advances have actually been made. The understanding of dual diagnosis, which we have now, was not available to earlier practitioners. The majority of adult mental health consumers in my county also have drug or alcohol problems (or both). It also seems that the number of young people who are simultaneously addicted and undergoing a psychotic process has increased over the last two decades. These clients are usually—and often quite arbitrarily—assigned a "primary diagnosis" of either drug abuse or mental illness, without careful assessment. We need assessment procedures that incorporate the "way," as well as research into what kinds of programs can most benefit dual diagnosis clients. They may not be served best by the loose structure of a 1970s-style program like Diabasis, but could be well served by an updated version that incorporated substance abuse treatment into the program design.

There was a strong tendency among earlier alternative practitioners, both Jungian and Laingian, to react against the medical model by insisting that biochemistry has no effect on mental states. This stance is still championed by Breggin (1991). A more holistic approach would assume that all aspects of a person are involved in any process and would support any intervention that actually facilitates the healing process, rather than merely suppressing symptoms. I believe that 21st century alternative treatment must address each patient as an individual. For example, judicious use of antidepressant medication, in concert with alternative treatment, might be found to be a life-saver for people who are simultaneously undergoing a psychotic process and a severe depression. This could also be true for a variety of alternative medical treatments, including simple changes of diet, such as eliminating caffeine or allergens. Windhorse, where "proper diet" and "appropriate physical therapies are considered, such as acupuncture, massage, or movement therapy" (Fortuna, 1995, p. 187), is more in line with this holistic perspective.

The version of Soteria House that currently operates in Berne, Switzerland, has incorporated the use of very small doses of anti-psychotic medication for some residents

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into their otherwise alternative treatment approach. They also have a research component funded as part of the project and Ciompi et al. (1992) have reported good results with their protocol. Nelson (1994) also favors this approach to medication and Windhorse uses medications "sparingly, intermittently, and for as long as is necessary, without committing to long-term maintenance regimens" (Fortuna, 1995, p.187). Nevertheless, my research and clinical experience lead me to believe that any neuroleptic medication serves to suppress the purposive healing process of psychosis and I would not endorse this "alternative" use of medication.

Perhaps an emerging model of treatment would involve a variety of alternative health care practitioners, including holistically oriented psychiatrists. Holistically oriented treatment models need to be supported by research; funding could be pursued through the National Institutes of Health's Center for Complementary and Alternative Medicine. I believe that future research on alternative treatment of psychosis should be positioned firmly within this larger health care movement.

I also believe that the most important implication of my study for future research is that doing such research requires that we create new programs to test the cutting edge of treatment efficacy. We are now attempting to do this in my county and John Bola, whom I mentioned above, has already expressed an interest in designing and implementing a sophisticated research project, which would be built into the initial design of the program. This model—the research component as part of the initial design of small pilot projects—is our best shot at reviving alternative treatment in the 21st century.

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Relationship of this Study to the Work of Jung and Perry

Before ending this discussion, I want to assert my belief that any in-depth discussion of Diabasis, which is the centerpiece of Perry's legacy, must take into account charges of unethical behavior with female clients that were made against him. Perry was removed from membership in the San Francisco Jung Institute in the early 1980s as a result of such charges. Peter Rutter, who was mentioned by one of my participants as a psychiatrist involved with Diabasis, told his version of this story (using a pseudonym for Perry) in his ground-breaking *Sex in the Forbidden Zone* (1989).

In my opinion, because Perry's revolutionary work on psychosis is such a valuable contribution, separate from Jung's, it has sustained itself and still enjoys a strong audience of supporters. Perry published yet another book in 1998, *Trials of the Visionary Mind*, and was much in demand as a speaker and teacher all over the world, right up to the time of his death. Similarly, Jung's reputation as a giant in the field of psychology is secure beyond any doubt, despite his long term (and very public) extra-marital relationship with a former patient, Toni Wolff, as well as his more recently disclosed affair with a patient named Sabina Spielrein (Kerr, 1993)—a revelation that seemed to shake the Jungian community.

Nevertheless, I believe the hard-won ethical imperatives of contemporary feminism, which were hardly considered in Jung's time, will cause history to be less forgiving to Perry, especially among Jungians. Perry repeatedly denied, both to me and to others, that he caused harm to any client. If, however, he did engage in inappropriate sexual contact with some female clients, which I believe he may have done, our first concern must be for them. As someone who for years counted Perry as a mentor and, finally, as a friend and colleague, I personally felt sad for him regarding this area, where he felt most misunderstood; to his death, he proclaimed his innocence. But, in the last

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months of his life, he defined that innocence to me in terms of moral relativism, arguing that our current age was not ready for the kind of "Tantric" spiritual intimacy that he shared with some of his clients.

Although Perry was speaking about his private practice—and I have never been given any reason to believe that anything inappropriate ever happened with hospitalized patients or residents at Diabasis—I believe that the controversy surrounding Perry's behavior has had severe repercussions for the "cause" of alternative treatment of psychosis. Again, this is especially true in the Jungian community. Given the hostile climate already created by its challenge to and competition with the medical model, as well as its use of paraprofessional staff, the cause could little afford to attract additional antagonism. Laing lost his license to practice psychiatry as a result of ethics charges related to alcohol abuse (Clay, 1996; A. Laing, 1997). Some other pioneers in this treatment revolution have also had feet of clay, as I know from personal experience. They have thereby afforded their opponents ammunition to use to discredit alternative treatment in general.

Perhaps the legacy of Perry and Laing may serve in part as a cautionary tale for those practitioners who would follow them into the world of alternative treatment. Such practitioners are immersed, daily, in the milieu of un-medicated madness, which itself is in opposition to the cultural constraints of the consensual reality which surrounds it. Without careful attention to shadow work and countertransference, without the utmost vigilance, even the most well meaning therapist may become unmoored.

Personal Statement (In Conclusion)

This dissertation has taken me a long time to complete After many years of struggle, I became aware that my progress was impeded by my resistance to the difficult emotions that would surface whenever I sat down to work on it. Over the last couple of

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years, as I struggled to complete this final chapter, many of my feelings involved my grief over the death of John Perry and my ambivalence over including my statement that I believed it was possible he had damaging sexual contact with clients. Perhaps this struggle is itself a cautionary tale, one about being both blessed and cursed by being in the orbit of a visionary genius and "great man."

However, throughout the years when I worked on the literature review and the results, I experienced other painful emotions every time I turned my attention to the project. I felt both deep sadness—a kind of mourning or grief—as well as burning anger, as I contemplated the demise of sanctuaries such as Diabasis and I-Ward (where I had worked). I shared this problem with John Perry, as well as with my other original committee members, David Lukoff and Minou Alexander. They understood the difficulties I was having, but urged me to continue anyway.

When writing about madness in his letter of support for Diabasis, Gregory Bateson referred to the "human spirit." His appreciation for the "precious" value of Diabasis echoes the haunting words of R., the resident I interviewed, who said, "it makes me sad to think that there is no place like that...no refuge. Because that's what Diabasis really was....It does matter. And for some of us it maybe matters more than for others."

Each time I approached work on this dissertation, I felt unable to ward off my awareness of the thousands—perhaps hundreds of thousands—of people in acute psychosis who were and are not "lucky enough," in Bateson's words, to enter a refuge like Diabasis. I was, and still am, struck by a sense of immense waste. The "human spirit" in many of these "unlucky" people has been diminished or broken. Many have chosen to kill themselves rather than endure the life sentence imposed by biopsychiatry, which refuses to provide the refuge that could heal them.

John Perry and I spoke, many times, about our pain as therapists who have actually seen people like R. receive and respond to what "matters," but who also know that so many others have gone without the kind of healing refuge they needed. We

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experienced a sense of unreality, as if this waste of life couldn't really be happening. In our discussions, we often tried to find some parallel that might enable other people to understand our pain and our outrage.

Perhaps it would be like being physicians who had specialized in the treatment of diabetes and seen, over and over, the life-saving effects of synthesized insulin. Imagine such a physician being told by the AMA that insulin was no longer an acceptable treatment for diabetes, that its use would be considered malpractice, and that no funds would be available for further research. Instead, the treatment of choice—and the only treatment doctors would be allowed to provide—would be seeing-eye dogs for diabetes-induced blindness and limb prostheses for diabetes-induced amputation of gangrenous extremities.

As a therapist who has worked in the public mental health system for over 20 years, I believe, without a doubt, that, at the very least, one half of those clients now categorized as Severely and Persistently Mentally Ill (or, more pejoratively, as "chronics") would not be *in* the system if they had found a refuge like Diabasis during their initial psychotic breaks. Having seen many clients whose initial experiences were similar to R.'s, I agree with her assessment of her chances without Diabasis:

> I can see now that if I had instead been sent to a hospital and been drugged up for a few days and then let out, then it would have been a circuitous process. Maybe I could have recovered to the point of continuing to plod along in my work. But it wouldn't have worked. Something would have happened, either physically or emotionally. It wouldn't have produced what I needed to produce.

The experience of working on this dissertation—reviewing the literature; interviewing John Perry, R., and the members of the Diabasis staff; and compiling and interpreting the results—confirms what I had already seen with my own eyes on I-Ward. Alternative treatment for psychosis, based on a model of refuge and rooted in the "way" of being with clients that Perry modeled so well, could absolutely revolutionize the fields and practices of clinical psychology, therapy, and psychiatry.

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Postscript, February 2002

He's almost 18. I'm 56 now, sitting in my office in the county clinic. I "inherited" the case: a big "ethnic" male "schizophrenic"; "won't take his meds"; "violent at times." In and out of the hospital. My "job" is to help him accept his "disease" and trust me enough to take his meds from me.

I've seen him for two previous one-hour sessions, during which I sat and listened while he talked non-stop in the loose rambling manner that everyone, until now, has interrupted. In all that time, I only spoke two or three sentences; instead, I nodded and responded more to what when his affect, rather than his very tangential speech, was telling me.

And now, finally, it starts coming out—all the hints, leads, allusions of the previous hours begin to come together, the affect and the images converge. Maybe because you understand, by now, that I don't care about their plans for you. The first moistening of your eyes, the trembling of your voice, your imploring glance to me, as you tell me of your grandfather who is dead and you, (a boy, you say) who was quiet on his lap, just watching and holding onto him, and your older sister gone (dead you said at first—I didn't even interrupt to confirm if really dead, but as I thought, and you say now, she's not really dead, but gone). Now, finally, your anger and anguish emerge.

"Yes," I say to myself, "I waited. I kept the faith. And, yes, old John Perry, I thought of you as I kept it."

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APPENDIX A

INFORMED CONSENT FORM

I, (_____), hereby willingly consent to participate in the follow-up research project on Diabasis to be conducted by Michael Cornwall, under the direction of Minou Alexander, Ph.D., of the California Institute of Integral Studies.

I understand the procedures to be as follows:

Michael Cornwall will explain the purpose of this study to me and I will read and sign this *Informed Consent Form*. I will then participate in a taped interview with Michael Cornwall, which will last about two hours.

I am aware that the potential risks involved in the study are minimal:

There will be no physical risks and minimal psychological risks involved in participating in this study. If I should experience undue emotional distress as a result of my participation in this study, I may have two consultations with Michael or, if I prefer, with another licensed professional, at no charge to me.

There is no expected benefit from participating in this study, other than the possibility of contributing to the psychological understanding of alternative treatment of psychosis.

I understand that I may withdraw from the study at any time. I understand that this study may be published and that my identity will be protected unless I give my written consent to such disclosure.

Date:_____ Signature: _____

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APPENDIX B

QUESTIONS USED IN SEMI-STRUCTURED INTERVIEWS

Questions for Resident Participant

1. Please describe the process you were going through that caused you to seek help at Diabasis.
2. How was the process you were going through affected by being at Diabasis?
3. Please share with me thoughts and feelings about Diabasis staff, both generally and specifically.
4. Please describe what your interactions with other residents were like for you.
5. Please describe contact with your family and friends while at Diabasis.
6. Please describe any difficulty with the method of treatment at Diabasis.
7. What, if anything, was helpful to you about the treatment at Diabasis?
8. What was it like for you at Diabasis after your process became less intense (if this occurred)?
9. What has the process that brought you to Diabasis come to mean to you as you have gone on with your life since then?
10. Please describe any particular post-Diabasis milestones regarding personal relationships, work, therapy/treatment, and spiritual practice.

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Questions for Staff Participants

1. What drew you to Diabasis in the first place?
2. What was your most memorable course of therapy with a client that highlighted the Diabasis approach?
3. What was it like for you as a primary therapist to work with unmedicated psychotic clients?
4. Looking back, how do you view the Diabasis approach and experience in general?
5. Did you integrate what you learned at Diabasis into your current practice and theoretical orientation? If so, how?
6. What were the pluses and minuses of the Diabasis approach, particularly the consensual, non-hierarchical staff structure?
7. Do you think some version of Diabasis would still be useful to clients today?

Additional Questions for John Perry

1. How has your theoretical formulation of psychosis evolved, from your years in Zurich to the present? How did the idea of Diabasis come to you?
2. Please describe the theoretical approach used at Diabasis.
3. Please describe the organizational structure of Diabasis and its day-to-day operations.
4. Please describe how Diabasis was planned and operationalized, how it interfaced with the mental health system, and why it closed.

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5. Do you distinguish between an "underworld soul journey" and a more "spiritual" kind of Renewal Process? If so, how?
6. What can you say about the presence and meaning of the "shadow" in the acute psychotic process?
7. What kind of approach to treatment of psychosis (both acute and post-acute) can you envision that would build on the lessons learned at Diabasis?
8. Do you believe that medication is the "treatment of choice" for some acute psychoses?

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