

Soteria Berne: 32 years of experience

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Summary

“Soteria Berne” is a small therapeutic community focused on a partly alternative understanding and treatment of acute schizophrenia. It was created in 1984 and continues to function successfully. Information on the basic concepts, the practical implementation and the therapeutic results of this pilot project have been published extensively elsewhere². The aim of this paper is to present a short overview of the three decades of experience, to discuss its position in mainstream psychiatry and to explore possible future developments.

Key words: schizophrenia; emotions; psychotherapy; sociotherapy; affect-logic

Historical roots and basic concepts

The Soteria Berne approach, started in 1984, was inspired partly by a previous approach used by Mosher et al. [6–8] in San Francisco, USA, bearing the same name (“soteria”, Greek, means safety and protection in this context) and partly by our own understanding of the schizophrenic psychosis based on the concept of affect-logic [1, 9, 10].

This concept aims at a clinically and theoretically relevant synthesis of current interdisciplinary research on omnipresent interactions between emotion and cognition [11, 12]. In addition, it is based on our empirical studies on the long-term evolution of, and rehabilitation of patients with, schizophrenia [13, 14, 15], and on extended clinical, psychoanalytic, socio-therapeutic and family therapeutic experiences with psychotic patients. Other constituent elements are Zubin’s and Spring’s generally accepted vulnerability-stress hypothesis [20] and about twenty empirical studies that confirm the existence of highly significant relationship between the outbreak of psychosis and the so-called high expressed emotions [16].

On this basis, the concept of affect-logic postulates that, contrary to widespread beliefs, overt or hidden emotions play a key role in the evolutionary dynamics of schizophrenia [17]. Of central importance is the fact that persons at risk for schizophrenia tend to develop acute psychotic symptoms when overtaken by a critical increase of emotional tensions related to

stress. The main aim of all therapeutic (and also preventive) measures against acute psychosis should therefore be the systematic reduction of the level of emotional tensions in and around a person at risk. This is, however, often far from sufficiently achieved in the usual hospital treatment of acute psychoses. Emotional tensions may even be increased, for example by nontransparent proceedings at hospitalisation, by too big, too complex and too often changing therapeutic environments, by too short duration of hospitalisation, by insufficient involvement with the relevant familial and social environment, or by too much promiscuity or violence in the therapeutic setting. Even the neuroleptic medication itself may sometimes increase rather than decrease the level of tension, for example by noncompliance and related compulsory measures. Altogether, such unfavourable factors may hamper the most important precondition for a successful therapy in our view, namely the building-up of a long-lasting and trustful “therapeutic alliance” between the therapeutic team, the patient and their relatives.

Practical implementation and organisation

In order to minimise such antitherapeutic influences as much as possible and, simultaneously, to actively induce sustained emotional relaxation, Soteria Berne is organised around the following eight principles [1, 4]:

1. A therapeutic setting that is small, open, relaxing, stimulus-protected and as normal as possible, outside conventional psychiatric institutions.
2. Continual personalised “being with” the psychotic patient during the acute psychotic state, by a specially selected and educated member of the therapeutic team.
3. Personal and conceptual continuity over the whole period of treatment.
4. Ongoing close collaboration with the family and/or other important persons of reference.
5. Clear and concordant information for patients, family and staff on the illness, its treatment and the existing risks and opportunities.

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² For basic information in German or English see ref. [1] or www.ciompi.com/fields_of_interest/Soteria_Berne, in French see ref. [2], in Italian see ref. [4]. For comprehensive presentations and critical discussions see refs [3–5].

6. Consensual elaboration, with the patient and representatives of the relevant social environment (family, working place, school, etc.) of realistic common goals and expectations for future housing and work.
7. Consensual low-dose (or, exceptionally, no dose) neuroleptic medication, in collaboration with the patient and their family, with the final aim of controlled self-medication.
8. Part-time or ambulatory aftercare and relapse prevention for at least 2 years, within the available integrative network of services.

The concept of recovery, too, is an integral part of the Soteria Berne approach.

Soteria Berne is located in a former boarding house in the midst of a normal housing development near the centre of the town (see photo). It offers rooms for nine patients, and at least two team members who are continually present. The treatment is subdivided into four phases characterised by different therapeutic proceedings and aims:

1. Emotional relaxation during the acute psychotic state.
2. Gradual integration into normal everyday activities within the therapeutic community.
3. Gradual reinsertion into the external world and preparation for discharge.
4. Ambulatory or semi-ambulatory aftercare.

Patients with a florid acute psychosis are continuously accompanied, 24 hours a day, in a stimulus-protected so-called “soft room”, preferentially by one of the two staff members (usually a man and a woman) directly responsible for the individual therapeutic programme and the relations with the family. During phases 2

and 3, everyday household activities like shopping, cooking, cleaning, planning, etc. are shared by all team members and patients, and integrated into the individual therapeutic programmes. The team consists of carefully selected and specifically trained nurses, psychologists, social workers and lay persons under the direction of experienced psychiatrists. In order to favour the building of trustful interpersonal relations, team members work without interruption for 48 hours in overlapping shifts, followed by several days of break. For half a day per week, the whole therapeutic team meets to transmit information, elaborate therapeutic programmes, and for periodic peer intervention and supervision.

Soteria-Berne is a specialised semi-private institution administratively supported by a nonprofit organisation, the Interessengemeinschaft Sozialpsychiatrie Bern (IGS). It closely collaborates with the local public psychiatric services and private practitioners. Its legal status is that of a psychiatric hospital financed by public health insurance and health services, which annually evaluate and compare its performance with that of other psychiatric institutions.

Clinical experiences and comparative research

The essential clinical finding that became obvious right from the beginning is that a great majority of patients suffering from acute schizophrenia can indeed be successfully treated in an alternative therapeutic setting of the type described, and that such a setting offers a number of at least subjective advantages (less stigmatisation and less traumatic experiences both for patients and relatives). Only about 10% of randomly assigned patients on average had to be referred to conventional closed institutions, because they consistently refused all collaboration, repeatedly ran away, or sometimes became too dangerous for themselves or others. Seriously dangerous incidents were extremely rare throughout the three decades, in spite of the open setting: there were in all about three life-threatening situations and four suicides in 32 years (all outside Soteria) among approximately 2000 cases in total.

According to our outcome studies, about two thirds of the initial cases were in complete remission or significantly improved at discharge. Outcomes after 2 years did not significantly differ from those achieved in four conventional settings in Switzerland and Germany, in terms of psychopathological state, working and housing situation, and relapse rates. These results were, however, achieved with highly



significantly lower daily and total doses of neuroleptics over 2 years [4, 18, 19]. Comparative outcome research in Soteria Francisco yielded quite similar or slightly better results [6–8, 21, 22].

Initially, daily costs and 2-year costs at Soteria Berne were considerably higher than those of conventional psychiatric settings, but they became consistently about 10% lower during the last 10–15 years, according to the official annual evaluations. This is mainly related to a progressive reduction of the initially much longer average duration (about 90 days) of the inpatient treatment in Soteria which aimed, during the first years, to include full rehabilitation. Currently it is about 49 days in average, thanks to the creation of an additional network of part-time and outpatient services for former Soteria patients, among them a protected apartment for 3 patients, a day-hospital for about 10 patients, an outpatient treatment and home treatment service for about 50–60 patients, and a centre for early detection and treatment organised in collaboration with the Bernese university department of psychiatry. Another cost-reducing factor is the already mentioned fact that all cooking and household work is part of the therapeutic programme and done by the members of the community themselves, without additional resources.

Personal contacts between former patients, team members and relatives usually remain friendly and cordial over the years, thanks mainly to very liberal visiting policies and regular monthly meetings between relatives and team members along so-called educational lines. Supportive long-term contacts with former patients are also promoted by three informal meetings with team members per year, and by the recent creation of a very popular mixed choir for former patients and staff members. Long-term evolution of former Soteria patients are still, however, only very partially known.

A recent tentative reinvestigation of 22 patients who had participated in the 2-year follow-up study 25–30 years ago partly failed, because only 11 former index patients could be located and were willing to collaborate. These 11 long-term catamneses provided a contradictory picture, obviously without statistic significance. However, they corresponded quite well to well known long-term evolutionary trends brought to light by a number of follow-up studies over several decades (among them our own [13, 14]) which revealed, roughly, about one third full remissions, one third minor residual problems, and one third severe chronic illness [23]. Three of the former 22 patients were dead, two of them by late suicide. These figures, too, correspond to known long-term trends.

According to these fragmentary findings, the early antipsychotic treatment in Soteria Berne had no significant impact on the often very complex long-term life evolution over decades, except generally quite positive subjective memories.

The position of Soteria in mainstream psychiatry and possible future developments

In spite of its more than three decades of successful existence, the Soteria approach remains marginal in current mainstream psychiatry. This is probably due to a complex mix of factors, among them structural and administrative obstacles, negative prejudices against alternative socio-psychiatric solutions, and, especially in academic psychiatry, the nearly absolute dominance of drug-centred neurobiological approaches during the past two decades.

Another important factor is the relative rarity of empirical research data on the Soteria approach and the lack of objective large-scale confirmation of its clinical value.

In spite of these shortcomings, the Soteria idea has continually spread since its first European implementation in Berne/Switzerland 32 years ago, firstly to Germany, where about 15 Soteria-like institutions have been created during the past 15 years. Similar institutions have also been established – under the same or another name – in the Netherlands, Sweden, Israel, Japan and the USA. An international Soteria Association was founded in 1997 in Switzerland and restructured in 2015 in Germany. Given the emergence of a great variety of Soteria-like institutions, a “Soteria fidelity scale” was recently created in order to objectively evaluate and compare their quality and organisation [24]. In addition, something that could be called “the spirit of Soteria” led to reforms toward more personalised approaches of humanistic or phenomenological orientation in many traditional psychiatric wards both in Switzerland and elsewhere, with or without explicit reference to the Soteria idea [25]. Pressure in the same direction is often exerted by a widespread dissatisfaction of user organisations with the too unilaterally neurobiologically and drug oriented modern psychiatry, which allegedly neglects both the person and the social context of the patients. More integrative approaches are, however, also supported by recent neurobiological findings that speak for a strong influence of environmental factors – and especially of the quality of interpersonal relations and the “emotional atmosphere” of therapeutic settings – on normal and pathological brain functioning [26].

In the light of such findings, we believe that the Soteria approach is much more than just a marginal psychiatric curiosity or a nostalgic relic of the last century. Both the daily clinical experience over more than three decades and the available results of empirical research prove its considerable therapeutic and theoretical potential. Therefore, it still appears to be a pioneering movement capable of inspiring development towards, hopefully, truly integrative psycho-socio-biological psychiatry of the future.

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