PROTECTING RECOVERY FROM PSYCHOSIS IN HOME ENVIRONMENTS

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The course of recovery from psychosis is a precarious and dangerous human event. It is a time of extreme vulnerability, of tenuous awakening from a dream, fragility of relationships, nostalgia for psychotic excitement, and painful oscillations between fear and well-being. As one recovered person described it, one reenters the world with a child's sensitivity and an imbecile's inability to control wild thoughts.[1]

There is a "natural history" to the recovery from psychosis, and when that natural history is obstructed or thwarted, one can become forever haunted by or fixed in psychosis. Thus, the developmental stages of recovery need to be understood, respected, encouraged, and skillfully guided. This is the principle behind the treatment program to be presented. The vehicle that has been developed to accomplish that treatment is the individually-designed, specialized home environment, or household.

Another principle of this treatment is that it must continually recognize the resistances, doubts, and fears that all who work with psychotic people share about psychosis and its possible outcomes. This is a significant aspect of the work done by a team of people working with a psychotic patient. The atmosphere of a treatment that leads to complete recovery must be free from the theoretical and personal prejudices which state that once a person has become insane, he will always be so, to some degree or other. When such an assumption exists, the intelligence and energy that begin to manifest during the recovery process will not be accurately recognized and appreciated. It will also not be recognized that a person who has recovered from psychosis is frequently

stronger in ability to live a meaningful life than he or she ever was before the onset of psychosis.[2]

PRINCIPLES OF PROTECTION

The design for recovery described here is based on the experience of the past several years, during which time a number of specialized households have been established and maintained as the place of treatment for psychotic people. Within the household are the patient and the roommates who live with the patient. Entering into this environment is a group of seven team therapists under the direction of the principal therapist.

This design may seem questionable to some because it requires a great, perhaps unheard of, amount of effort, training, and dedication to the work. To others it may be questionable because so much care and attention is given by so many to so few. There might even occur a moral outrage: psychotic people should not be treated so richly; there is a certain virtue to harsh treatment. This latter view recalls a psychiatric proverb about psychosis from the nineteenth century—their glory was their sickness, their cure must be their humiliation.[3]

ENVIRONMENT

In the treatment of psychosis, equal emphasis is placed on the human and non-human aspects of the environment. Because we know that environment and mind continually imprint each other, the recovery process depends on creating an atmosphere of simplicity and dignity, curiosity and truthfulness. Contrary to past assumptions, the turmoil of the psychotic mind is excessively burdened when it is in close proximity to environmental chaos and other confused minds. Inside the asylum, whatever comradeship may exist among

the insane tends to be based on defiance of authority and shared complaint against institutional life and the failures of communication with therapists. It has been repeatedly noted and proclaimed by those who have recovered from psychosis that highly disturbed people, when grouped together, run the risk of becoming more confused; when they are in the company of healthy people, they are likely to become more healthy.

Once established, the treatment household provides an invitingly simple and decent environment. Carefully chosen foster-friends join the treatment team and function as roommates, companions, and administrators. This household becomes the center of activity for the patient's treatment. Its maintenance, the quality of its relationships, and its capacity for hospitality, are focal points for every therapist involved with the patient.

A daily schedule is gradually introduced. This provides a meaningful pattern to the patient's day, and attends to the needs of each successive stage of recovery through which the patient passes. Particular attention is given to sleeping-waking rhythms; eating habits; toilet, bathing and dressing habits; and regular appointments with team members, who provide a wide variety of increasingly close relationships. Relating to such a schedule becomes an important practice that sharpens the patient's awareness of the boundaries of inner and outer experience, and in particular, the boundary between indulging in daydreams and paying attention to the world around him or her. At each stage of the recovery, new means for increasing this crucial level of discrimination are introduced.

Concurrently, relationships with the small team of therapists begin to develop. The team members' homes, families, and friends begin to be included in the larger environment of the treatment situation. This team constitutes a social fabric that is most analogous to that of a tribe or clan.

BASIC ATTENDANCE

A team therapist mediates the interaction between the patient's environment and the patient's mind, regardless of whether that mind is in turmoil, or is stable and clear. The purpose of attending to that interaction is to promote further body and mind synchronization, sharpen attention, and develop concentration skills. This is "the work" of the therapists. This work is highly skilled, and learned during much supervised practice. It begins with the first contact with the patient, and continues to develop through each successive stage of recovery.

The psychological health and development of the therapist is, as always, a crucial aspect of the patient/therapist relationship. The warmth, gentleness, courage, and basic cheerfulness, which are required to attend someone through the phases of repair and recovery, can be continually developed. The therapist can cultivate these necessary attributes through the practice of "mind training," to be described later. From this discipline arises a variety of interpersonal practices based on the growing awareness of how one can be authentically present in a relationship and how one can stimulate healthiness and sanity in another. This work is experienced by therapists as a vital part of their maturation both as friend and therapist within the patient/therapist relationship.

THE TEAM THERAPISTS

Each of the seven team therapists is with the patient for a three-hour block of time, twice a week. The roommates—usually two—are available several hours a day and provide the back-bone of the household. The principal therapist meets with the patient for one hour several times a week. In this way, at the beginning, the patient is closely involved with team members at least seven hours a day. These relationships

are predictable, unpretentious, and free from the psychologizing that might make a patient feel damaged or dependent. Eventually, genuine friendships arise between the patient and the therapists. The patient experiences the gradual development of mutually caring relationships, and he or she discovers an increasing interest and concern for other people that is beyond the painful self-preoccupation with illness. The result of this experience brings a sense of ease and freshness.

In this treatment situation the therapist has great flexibility and mobility in working with the patient. The therapist's work can occur in any environment: in the kitchen, in the mountains, at the schoolyard, at an old age home while doing volunteer work, or at the theater. The patient is allowed to experience and see thoroughly the entire cycle of activity that occurs during recovery: the initial hesitation, the inability to start, the wild enthusiasm or immediate sense of failure, and finally the sense of completion. What generally evolves is that the patient gravitates toward a particular discipline of activity with each therapist, one they both enjoy and can explore together. These activities have been, at one time or another, disciplines of cooking, hiking, flower arranging, martial arts, calligraphy, music, pottery, learning a foreign language, or working with children or dying people. Sometimes the activity may be simply reading aloud to each other.

When engaged in properly, each of these activities can become important practices of how to relate calmly and accurately to one's mind, that is, *how to stabilize the mind.* It is the specialized training of the therapist that allows him to quickly identify and transmit each type of practice needed by the patient. As such situations and experiences accumulate, the patient learns how to be more completely present in every situation. In so doing, he or she learns how to renounce a variety of addictions, and gradually turns away from psychosis.

THE PRINCIPAL PSYCHOTHERAPIST

The role of the principal psychotherapist is to supervise the work of the team therapists, conduct intensive individual psychotherapy, and be ultimately responsible for the health of each individual household.

Supervision is accomplished through direct guidance by the principal psychotherapist of the therapist chosen to be the team leader. The team leader, in turn, conducts the clinical supervision of the team members and roommates. In addition, the team leader supervises and monitors the wholesomeness of the household situation.

Supervision by the principal psychotherapist also takes place in weekly team meetings which are attended by the entire team, the roommates, and eventually the patient. These meetings create an overview and are concerned with the well-being of each team member, as well as the patient, and the growth and capabilities of the team as a whole. At such meetings, all scheduling is done, households are discussed, conflicts are exposed, medication changes are made, dinner parties are planned, and disciplines are investigated. The patient's family members are occasionally invited to these team meetings. These meetings are powerful events that have their own journey of development. When this development is understood, it reveals the nature of each stage of recovery from psychosis.

The discipline of intensive individual psychotherapy is a vast area that requires elaborate discussion in another context, but several guidelines can be pointed to here.

First, the principal psychotherapist must thoroughly experience and understand the principles of basic attendance, as discussed earlier. Once again, an authentic therapeutic friendship is the ground on which psychotherapy takes place. The oscillations, complications, distortions, and intelligence within such an intimate relationship become the starting point to teach further methods of how to stabilize one's mind within the various energies of emotions.

Second, intensive psychotherapy allows for the complete exposure of how one became ill—that is, how one lost control of one's mental processes—and beyond that, how such a predicament may continually recycle within the intimacy of relationships.

Third, an atmosphere is promoted in which the stages of recovery can flourish. The intensive psychotherapy becomes the opportunity to shift one's allegiance away from illness and delusion toward the clarity of wakeful experience. This is accomplished within the relationship by attending to and encouraging all the intelligent, healthy impulses that have become obstructed and distorted by long periods of confused, fearful mind. It involves establishing a relationship with a patient's "history of sanity."[4]

Fourth, there is the mutual discovery of courage within the relationship. That is, there is no need to wait for the pain of the nightmare to be over; one can proceed with a precise and decent life right within psychosis. There is still much healthy and useful living to be done. It is the frustration and inhibition of sane impulses, such as being useful to other people, that has been among the most important origins of illness. Basically speaking, intensive psychotherapy is a journey toward unlocking and developing compassion, both toward oneself and toward others.

Finally, of utmost importance for our work—and something that is rarely discussed by others treating psychotic patients—is a function of mind that is continuous throughout the most wild hallucinatory psychosis. This quality of mind is best described as a sudden shift in awareness that discriminates between dream and reality. Psychotic mind is spotted with islands of such wakeful clarity. The therapeutic relationship can be one that points to and encourages the gathering of this wakefulness, which *always* exists side-by-side with delusion.[5] Unless the therapist can learn to detect and experience the nature of that wakeful quality, both in himself/herself and in the patient, there will always be doubt about the capacities of someone who is or has been psychotic.

This is one of the crucial issues in the gradual development of the therapist who works with psychosis.

MEDICINES AND MEDITATION

The idea of treating psychotic and post-psychotic individuals through disciplined relationships and without medication—a discipline long-charted by a lineage of psychotherapists[6]—is not only rare, but almost under suspicion of being negligent treatment. The treatment program described thus far uses medicine in a different way than is conventionally prescribed. In order for people to pass through the stages of recovery properly, they must have, so to speak, all of their wits about them. Any medicine is avoided that interferes with the patients' clarity of observing mental events or that obscures their ability to practice stabilizing the mind.

In general, there are *three ways in which people actually experience the effects of medicines that profoundly affect the mind:* as causing sleep, as heightening perception, or as clouding awareness. It is those medicines that cloud the clarity of mind which are particularly dangerous to the process of recovery. Nonetheless, even those medicines, when used along with other tools of mind training, can be effective during the appropriate stage of recovery. The major point in medication useage is to insure that the integrity of the wakeful quality of mind is protected. The natural and inherent precision that can accurately discriminate dream from reality requires protection.

In fact, the purpose of every methodology used in this treatment program is to provide and establish a wide variety of situations that will settle or relax the tremendous speed and aggression that characterizes psychotic mind. The result of such mental speed is a strong tendency to wander, and a restlessness that leads to impatience and distraction. Eventually, there develops a fascination and intoxication

with one's own thought creations. In this treatment program, many simple exercises are woven into daily activities in order to counteract those tendencies.

In order to help our patients become less attached to the colorful and beguiling contents of their own mental creations, we have found that it is important to personally practice and study ways and means of doing that. There is much that can be learned, and then taught, about how to work directly with mental confusion. However, this cannot be done through an academic psychological theory or philosophy. Thus, we find that it is extremely useful for team members to be personally involved with a genuine mindfulness-awareness meditation discipline. This is a practice common to all Buddhist traditions, known as "taming the mind" because it trains one to be more awake, alert, and precise about the details of experience. It is also known as "recollection," because it evokes a reminder to return from the hectic activity of discursive thought and fantasy to calm alertness. Although the team therapists train in this discipline, it is not required that the patients practice it. Nevertheless, those patients who have gravitated towards it—over half of the currently treated patients—have found that it greatly accelerated their course of recovery. The beneficial effects of mixing psychotherapy and meditation are beginning to be understood.[7]

A CASE HISTORY OF TREATMENT

I was asked to consult with a twenty-nine year old woman who had been admitted to a local psychiatric hospital. She was in an extravagant psychotic condition. I treated her on the acute inpatient unit for a period of four months, with daily intensive individual psychotherapy and medication. Her psychosis involved an extreme wandering and wildness of mind, out of which she had created a metaphysical theory and a conviction about her central position in the world. All

of her perceptual distortions and perverse actions were in the service of making that theory seem true. During the previous twelve years she had endured several long-term hospitalizations for the same condition, with the severity of each episode escalating.

During the first two months of her treatment, she created continuous crises of management. The concern was how to sedate her seemingly-intractable insomnia, and to corral her frantic delusional activity and occasional acts of violence. She lived inside a magic show of mistaken identities, miraculously appearing and disappearing entities, and passionate fusions with presences around her.

The early phases of her recovery proceeded well enough, so that she was able to leave the hospital and enter the protected environment of the treatment program described earlier. The household was established with a female roommate, the roommate's daughter, and the patient's sister. The roommate would frequently attend to the patient full-time, especially during periods of the patient's tremendous anxiety, which arose during recovery. Although the treatment program lasted seven months, the roommate and the patient continued to live together an additional year and a half, and eventually became close friends.

Medication was used only during the institutional phase of treatment. Upon leaving the hospital, the patient's medication of one hundred milligrams of Stelazine was slowly reduced. A slow and carefully observed process of reduction was initiated with the patient. The effects of the reduction were studied with her as a discipline of observing subtle changes in states of mind. This reduction was completed over a period of three months. The team members gradually introduced the patient to the world around her. Together they hiked, studied the geography of the area, skillfully conducted household activities, and so on. Within the context of all those ordinary activities, the patient gradually began to learn how to recognize and tame the abrupt appearances of a suddenly wild mind.

The step-by-step disentangling of oneself from the fascination and magnetism exerted by a systematic delusion is a grueling experience. The initial enthusiasm of our work clashed with the patient's enormous sense of fatigue. From her, we learned of the overwhelming need for sleep that is required early in the recovery process.

As the patient's mind cleared of confusion, and confidence appeared in her relationships with a variety of people, the issue of her entering into some form of meaningful work arose. This became a major conflict in her life, as it must during the later stages of recovery.

Approximately three months after a slow termination from the program, the patient solved the problem of how to endure the hardships of the reentry stage of recovery. The hallmarks of the reentry stage are fear, discouragement, and the risk of the return of insanity. At first she did manual labor, but then remembered an old, almost forgotten, desire to work with the elderly. She went to work for an organization that specializes in the care of the elderly in their own homes. Over the next year she worked strenuously with old and dying people, and eventually became an administrator in that organization. It was obvious that she was transplanting everything she had learned about basic attendance into her own work with people.

Her meetings with me continued past her termination with the formal program. The frequency of these meetings was gradually reduced to one every month or so. I also occasionally saw her at the birthday celebrations, holiday parties, and housewarmings that were created by the multiple households currently in operation.

PRINCIPLES OF RECOVERY

Recovering patients report that there are a number of notable experiences in the course of their treatment that must

be acknowledged and attended to by themselves and their therapists.

There are experiences of sudden shock or astonishment, a momentary clarity and awakening. At such moments, one patient said, "scales fell from my eyes." Often, these are moments of horror at the self-deception one has been immersed in.

There is also a more gradual awakening that occurs in the intervals between these sharp points of clarity. This happens bit-by-bit, sometimes with agonizing slowness, sometimes with bitterness, but also accompanied by moments of delight and confidence. Such awakening from delusion happens over and over again, and the effects of its progression are cumulative. This process of awakening certainly requires an active effort. It needs to be continuously maintained by anyone recovering from psychosis. In fact, the after-effects of psychosis are such that the effort to stabilize one's mind will need to be continuously maintained throughout one's life.

Each step of recovery has its own danger. For example, one may feel drawn back into the whirlpool-dream of psychosis, which is powerful, beckoning, and sometimes irresistible. Or one can become enamored with the sudden awakenings and then easily miss the point by perverting them into self-aggrandizements. Sometimes there is even an attempt to manufacture them for that purpose. During periods of gradual awakening, there is a feeling of exquisite precariousness. An undertow of grief and a powerful nostalgia for the brief experiences of happiness during the delusion, seemingly call one to relax into the psychotic dream. Compared to the vivid display of losing one's mind, the boredom of recovery feels hopeless. One's intention and effort may give way. Courage is the best word to describe what is needed to accomplish the dangerous pathway to recovery.

STAGES OF RECOVERY

Recovery is not a distinct event or a border to cross over. Moments of recovery are happening all the time, even in the midst of wild mind. Spontaneous insights present themselves as veiled messages within the delusion, and they are either recognized or lost. Most people have the capacity to recover from psychosis, but if any stage of the natural unfolding of recovery is thwarted, frustrated, or actively opposed by the environment, the awakening process is either abandoned completely or becomes a grim struggle with oneself and the environment.

It is being proposed here that recovery can be accomplished in stages similar to the following description, a virtual unwinding of psychosis. These stages are described from the point of view of the patient's experience. They particularly emphasize moments of recognition of and insight into the mechanics of one's own psychosis. Beyond that, they are intended to highlight the course of action that is required both of the patient and of those attending him. This presentation of stages of recovery is not meant in any strict chronological sense, because elements of each stage appear throughout the recovery process. However, experience shows that the course of any one patient's recovery follows a sequence. It is more to the point that each stage is a state of mind, with its own emotions, its own logic, and its own dilemmas. Thus, the following presentation of stages of recovery is meant to be a useful guide, which defines the predicaments inherent in the recovery process. In this way, recovery might be accomplished without the enormous number of obstructions and endless side roads that usually lead to a pattern of chronicity and hopelessness of maintenance.

I. *Detachment from Delusion*

As a psychotic experience wears on, it becomes increasingly apparent to the patient that there seems to be no way to avoid attempting to comply with the commands of the delusion—it is the nature of a delusion to demand action—except through one's own death. It is experienced as a total enslavement. All one's determined efforts to submit to the delusion in the past have only ended in failure to satisfy its demands. This can be a period of great grief. Only the patient's repeated recognition of the false promises made by the delusion can awaken his or her resistance. This is the beginning of the end of the bondage.

Now it is possible to begin the gradual dismantling of the delusion. Yet with each moment of clarity, there may appear a new edition of the delusion, a compromise that incorporates the increased awareness but *still* exhorts one to maintain an allegiance to miraculous powers. One begins to suspect that the powers, presences, or voices are as confused as oneself. Contradictions in the commands of different delusions become obvious. Doubt about the authority of the delusion arises and a new relationship with the psychotic world begins to take place. As one continues through the stages of recovery, the command voices of the delusion are gradually weakened and eventually terminated, one by one. In the experience of a long psychosis (i.e., 3 years), a great many independent delusions may accumulate. These delusions are also dissipated one by one, a process often lasting long beyond the initial stages of recovery.

II. *Discipline and Effort*

With each experience of disobedience to the delusion, there may occur a relapse into obedience. Only further discipline, effort, and understanding can counteract the tendency of insight to deteriorate. One person reported that the voices

themselves began to urge him to "recollect" himself, to prevent "going into a wrong state of mind . . . by keeping my head to my heart and my heart to my head. . . . Without that, my head wandered all through the day." This discipline is effected most directly by remembering to bring oneself back to the details of the sensory world, and in particular, to those activities of body and mind synchronization that have already been found to strengthen the ability to doubt and resist the delusion. Conviction in a delusion is eroded by perception of even the most simple truths and ordinary life experiences that contradict the delusion. These awakenings also lead to the growth of determined opposition to the arrogance of the delusion.

III. *Discovery*

Because the perceptual world is increasingly attended to and acknowledged as true, interest and curiosity about the world outside of delusion is naturally aroused. Such curiosity can become a playful opportunity to make numerous distinctions and discriminations between reality and the occurrences within the thick veil of illusion. The recovering person begins to acknowledge, at least to himself, the persistence of his tendency to "dream," that is to say, he sees exaggerated images of memory and desire instead of experiencing simple sense perceptions.

Sudden shocks of absurdity occur. One person said, "As I came gradually to my right mind, I used to burst into fits of laughter at the discovery of the absurdity of my delusion." It is a time of experimentation with illusion. One can recognize the insidious progression of tricks of the eye or ear, the whole dynamic that leads to granting an illusion independent existence.[8] Then it becomes obvious how disordered sensations, together with wildness of thought, create a compelling, hallucinatory world, and how true madness lies in the conviction in and response to that creation.

The end result of this stage of recovery has been expressed in this way: "Though I still occasionally heard these voices and saw visions, I did not heed them more than I would my own thoughts, or than I would dreams, or the ideas of others. Nay, more than that, I rather acted diametrically opposite to them, hating them for having deceived me. My organ of sight and of hearing may have been still disordered, but not my understanding."[9]

IV. *Courage*

As one gradually learns how illusions and delusions are formed, there arises a determination not to be deceived, but to follow a plan of action that will stimulate health in *all* aspects of one's life. There is also a gathering concern for other people's health and a recognition of the importance of giving aid to others. But concern for the welfare of others might escalate into a wild enthusiasm, during which time the tendency to form delusion is greatly exaggerated. That is because impulses to repair or heal others, even the world, that were raised to grandiose and messianic proportions, motivated the original delusion.

The singular importance of an interest in, or even a dedication to be of service to, other people has been repeatedly stressed throughout this presentation of recovery. This fact of the recovery process may appear idealistic or unscientific. However, all the evidence indicates its central position in the later stages of recovery. In this stage appears the dilemma of how to lead a meaningful and useful life, how to structure or channel the unleashed energy of recovery. Conflicts about work and livelihood arise. Nevertheless, resolutions are made and plans can be followed through.

There is a further discovery to be made during this process of reentry. That is, having once been insane, one lives in a world where other people distrust and suspect one's health, vulnerability, and motives. If the recovering person is to

speak openly and truthfully about his treatment or to proclaim plans of action, there is always a risk that he or she will still be labeled psychotic and untrustworthy. This creates an atmosphere of fear. The recovering person becomes concerned about his own mental abilities, and the question arises whether he will be driven crazy again in this predicament.

During recovery from psychosis one has to face the many consequences and effects of actions committed during the delusional state of mind—i.e., the alienation of family, the lost time, the embarrassments. It is again a quality of courage that is needed not to dwell on the shame of past mistakes, passions, and outrages. The development of courage thus becomes the single most important pathway for going forward with one's life.

V. *Relaxation*

Alongside all the difficulties encountered during the process of recovery, there also occur moments of relaxation and delight. These can appear during any stage of recovery, but they develop further as one becomes able to recognize that so much that one took for the fantastic and miraculous was merely the play of the mind. Then one can relax in an appreciation of the vividness and textures of the sensory world. Sometimes this is described as "joyfulness," a quality of pleasure or feeling of preciousness at being alive and sane. It is at such times that one's compassionate urges, and the ability to offer courage to others, are ripened.

The stages of recovery from psychosis are an organic development if the necessary environmental and interpersonal conditions are provided. That is, the treatment situation must simultaneously clarify and enrich the patient's wakefulness, general health, discipline and courage.[10]

The treatment program that has been described is designed to unobstruct and simplify the natural progression of recovery from psychosis, or from any highly disturbed state of mind. The process of recovery is more straightforward than is generally believed when treatment occurs in as natural a setting as possible—a home-like environment—and when the therapeutic relationships continually attend to the disconnection between mind and environment. As we begin to understand how people actually recover from psychotic states of mind, more creative ways of establishing sane or healing environments become apparent.[11]

NOTES

1. Perceval, John, *A Narrative of the Treatment Experienced by a Gentleman, During a State of Mental Derangement; Designed to Explain the Causes and the Nature of Insanity.* London: Effingham Wilson, 1840, Volumes I and II. The description of Perceval's insanity, recovery, and his innumerable suggestions for treatment environments, have strongly influenced the development of this work.
2. Adolph Meyer at Johns Hopkins emphasized the importance of recovery from psychosis with "increment instead of decrement" as early as 1905. Personal communication, W. R. Clifford Scott, M. D., Montreal, Canada.
3. Foucault, Michel, *Madness and Civilization, A History of Insanity in the Age of Reason.* New York: Pantheon, 1965, p. 261. See also Scull, Andrew, *Museums of Madness: The Social Organization of Insanity in 19th Century England.* New York: St. Martin's Press, 1979.
4. See Podvoll, E., "The History of Sanity in Contemplative Psychotherapy," *Naropa Institute Journal of Psychology,* II, 1983; and Searles, H., "The Patient as Therapist to His Analyst," *Countertransference and Related Subjects.* New York: International Universities Press, Inc., 1979.
5. See Podvoll, E., "Psychotic States of Mind," *Naropa Institute Journal of Psychology,* I, 1980.
6. The psychotherapists referred to in this country include Frieda Fromm-Reichman, Dexter Bullard, Harry Stack Sullivan, Lewis Hill, Otto Will, and Harold Searles. Recently, it has been learned that there is a great correspondence between the work described here and that of Manfred Bleuler and his associates. Personal communication, Manfred Bleuler, M. D., Zurich, Switzerland. See Bleuler, Manfred, "The Long-term Course of the Schizophrenic Psychosis," *Pscyhological Medicine,* 4(3), 1974, pp. 244-254; and Bleuler, Manfred, "On

Schizophrenic Psychosis," *American Journal of Psychiatry*, 136, 1979, pp. 1403-1409.

7. See Kutz, I., Borgsenko, J., and Benson, H., "Meditation and Psychotherapy: A Rationale for the Integration of Dynamic Psychotherapy, the Relaxation Response, and Mindfulness Meditation," *American Journal of Psychiatry*, 142:1, 1985.
8. For further description see Podvoll, E., "Psychosis and the Mystic Path," *The Psychoanalytic Review*, 66, 1979; and "Megalomania: Psychotic Predicament and Transformation," *Naropa Institute Journal of Psychology*, II, 1983.
9. Perceval, John, *Perceval's Narrative: A Patient's Account of His Psychosis*, ed. Gregory Bateson. Stanford, CA: Stanford University Press, 1961, p. 329.
10. A more fully discussed and documented description of the stages of recovery will appear in: Podvoll, Edward, *Intelligence Running Wild: Psychosis and Recovery*. Boulder, CO: Shambhala Publications, to be published 1986.
11. In 1835, Jean-Etienne Esquirol, one of the giants of French asylum reform, commented on the social activism taking place in England under the leadership of a recovered patient:

> I do not know how it is in your country, but in this country it is remarkable that all the great improvements in the treatment of the insane have begun in private asylums, whilst the public institutions have stood still, and have with difficulty been persuaded—or enabled by the Government—to adopt them. We have no reason to believe that we have at all arrived at perfection in this science, but if all institutions of this kind fall into the hands of the Government, we shall probably remain where we are. Therefore I am not of the opinion that we ought to abolish private lunatic asylums.

Perceval, John, *Letters to the Right Honorable Sir James Graham, Bart, and to Other Noblemen and Gentlemen, Upon the Reform of the Law Affecting the Treatment of Persons Alleged to be of Unsound Mind.* London: Effingham Wilson, 1846, p. 50.