THERAPEUTIC HOUSEHOLDS

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> If somebody is dancing in the sky and breathing air, that is worse than if he is sitting on the earth, eating dirt—which has more potential. It's as simple as that!
>
> Chögyam Trungpa, Rinpoche (1983, p. 10)

It is refreshing to encounter a clinical intervention, in the vast array of modern psychotherapeutics, that is simple, effective, has withstood the test of time, and is grounded in common sense. "Therapeutic households" is one such refreshing situation. Therapeutic households, as "domestic ground," is the experience of earthy practicality that is the literal basis of human life. As "domestic discipline," it is the practice of working with the elemental details of ordinary life situations with attentive respect. As "domestic harmony," it is the establishment of an open healing environment that supports wholesome human relatedness. This precise care of domestic ecology encompasses the lives of everyone involved in the treatment of and recovery from mental disturbance, and is the cornerstone of any flourishing community or culture.

The impulse to provide household treatment for disturbed persons has manifested historically in a variety of forms. The Geel Community in Belgium (Parry-Jones, 1981), founded in 1480, demonstrates the large-scale effectiveness of this social arrangement. At its height, the Geel Community successfully cared for 15,000 mentally ill people within the local, rural community.

Bruno Bettleheim, the world's foremost authority on the treatment of autism, wrote the following description of his own experience.

> From 1932 until March 1938 (the invasion of Austria) I had living with me one, and for a few years two, autistic children. To make this a therapeutic experience for them, many conditions of life in our home had to be adjusted to their needs. This was my initial experience with trying to create a very special environment that might undo emotional isolation in a child and build up personality (1967, p. 8).

Ex-mental patients have advocated for this kind of treatment for as many as 150 years (Perceval, 1961), and it appears to be generally appreciated as a commonsensical idea. However, most attempts to create therapeutic households have lacked the theoretical views, skillful means, and practices needed to accomplish this intention.

In modern Western treatment, the mentally ill are often grouped together or hospitalized in inpatient settings, transitional halfway houses, long-term group residences, cooperative apartments, lodge programs, rural environments, crisis centers, nursing homes, and board-and-care homes (Lamb, 1984). This treatment pattern carries several liabilities: it fosters a chronically mentally ill life-style based on diagnostic stigma; it creates a medical-psychiatric establishment with the potential to abuse power (Perceval, 1961; Foucault, 1965); and it compounds the effects of mental illness by creating settings in which patients' psychopathologies overlap. "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" (Podvoll, 1985). With the failure of deinstitutionalization and increasingly inadequate funding, the problem of providing decent housing and residential treatment for the mentally ill is acute. The result of this unmet challenge is clear: "Depriving the chronic patient of food, shelter, and clothing, thus subjecting him to the vicissitudes of the elements, undoubtedly contributes to his deterioration and repeated decompensations" (Lamb, 1984, p. 157). This situation is reaching the proportions of a national emer-

gency and requires resourceful innovation in order for positive change to occur (Pollack, 1977). It is within the context of this urgency that the following model of therapeutic households is presented.

My intention in writing this article is to elaborate on the principles of the specialized treatment households described by Edward Podvoll (1985) in his presentation of Maitri Psychological Services (MPS). MPS is a comprehensive treatment service that provides individually tailored care for psychologically disturbed persons. The three interrelated components of this service are: 1. therapeutic households, which are established as the locus of treatment, 2. basic attendance provided by team therapists, and 3. intensive individual psychotherapy provided by a primary therapist. To isolate one of these components for the sake of discussion could be misleading to the reader because all three interact to form a total environment. The MPS approach departs from mainstream psychiatry in avoiding the grouping together of disturbed persons in one facility. Instead, each MPS patient lives with two housemate-therapists in an ordinary household setting in the local community. This situation is similar to a foster care arrangement.

This article is addressed to concerned professionals, mentally disturbed persons, and friends and family members of the mentally ill who are faced with domestic chaos and confusion. This article can be used as a practical guide or "recipe" of environmental healing principles. These principles are applicable to the households of *both patients and therapists*.

THE ADMISSION PROCESS: MUTUAL INTERVIEWING

A prospective patient enters the MPS program through a process of mutual interviewing during which everyone gets to know one another. The applicant and his[1] family members meet with the MPS senior clinical staff to explore the potential

patient's current problems, aspirations, and intentions, as well as what MPS can offer to him. The applicant meets with several team therapists for three hours at a time to sample a variety of activities and relationships, and to articulate personal interests, talents, and disciplines. In addition, the potential patient consults individually with the primary therapist to discuss the interplay of health and illness in his personal history and to briefly experience the interpersonal openness that is the basis of intensive psychotherapy (Podvoll, 1985). The applicant visits several existing treatment households to candidly discuss the MPS program with patients and roommates. This discussion can range from the level of housework to the unraveling of complex delusions. These meetings with current patients and/or past patients—"graduates"—of the MPS program are especially poignant; they often include the sharing of personal hopes and fears, stories of failures in other treatment settings, and glimmers of enthusiasm about the recovery of a meaningful life. This experience contrasts with the often dire diagnostic predictions of medical specialists—for example, that one is destined to a life of chronic psychosis. The applicant's family members are encouraged to participate fully in these discussions.

The overall tone of the interview pattern is one of candor, inquisitiveness, and genuine human contact. This thorough interview process, lasting several days, is necessary in order to elucidate the nature of the MPS program and to discover a mutual working basis. An essential component of this working basis is an active interest on the part of the clinicians, the potential patient, and the patient's family in making a personal commitment to the work: we do not accept patients against their will. If the proper conditions exist, a six-month commitment to the program is requested of the patient and family. Our experience has shown that this amount of time is necessary in order for the patient to settle into the therapeutic household and new interpersonal relationships. Several

months are needed in order to ascertain whether or not the patient is making significant progress through the stages of recovery (Podvoll, 1985). As well, this commitment allows sufficient time for the patient's family to contribute their own sanity into the program by helping to set up the patient's household and permitting the treatment team to share in their understanding and appreciation of the patient.

DOMESTIC GROUND: EARTHY PRACTICALITY

> *Establish the household: Involve the patient in a collaborative effort to create a decent, simple, and cheerful place to live.*

Rather than admit the patient to a preexisting facility, the MPS staff, along with the patient, work to create a fresh household environment. This is in itself the beginning of treatment. Initially, a team leader and a team of therapists are selected to join the primary therapist in working with the new patient. Then, individual and group meetings are scheduled. The group's primary task is to find two housemates, one female and one male, and a suitable house to rent. This may be the first time the patient has helped to establish a home and find housemates. The patient's family members are encouraged to remain in town for two weeks to facilitate the patient's difficult adjustment to a new place and new people. In the beginning, patients may fear that they will be unable to cope with the many details that demand their attention in this new setting. However, with the support of the MPS team these intimidating tasks become opportunities for resourcefulness. All of our patients have surprised themselves in this regard. They are always more capable than they had anticipated and all of them have felt the grounding and strengthening effects of these practical beginnings. The experience of the MPS staff is

that this phase of collaborative treatment is important in setting a tone of mutual respect and cooperation.

> *Pay deliberate attention to details: Emphasize an earthy simplicity in arranging the domestic environment. Domestic details become the "pull of gravity" or antidote to mental wandering.*

The patient confronts real choices. For instance, what kind of house does he prefer and in which part of town? What colors, what window sizes, and how much light does he prefer? Will pets be allowed in the household? Does he want a garden to cultivate or a yard to care for? Confronted with these details, the patient's ordinary, but perhaps atrophied, sense perceptions, discrimination, and concentration begin to awaken. This increasing alertness moves the patient beyond painful self-preoccupation, confusion, and the cloudy hangover of previous institutional life. One patient described this process as follows:

> For me, this raised some interest in the outer world, for example, making decisions on the basis of what would I like? how do I want to live? This was in contrast to the flat, institutional environment I came from, in which I had no ability or right to exert myself [in] this way—a very simple, practical, and, thus, refreshing task.

Chögyam Trungpa emphasized the importance of this mundane approach:

> Try to work with the pinpoint of the situation by being very practical and ordinary. Working with environment basically means bringing people down to earth. If a person suddenly loses his gravity and floats up to the moon, he wants to come back to earth: he may be willing to become sane. At that point, you can teach him something. He will be so thankful to feel the gravity on the earth. You can use that logic in every situation. Earth is good (1983, p. 10).

Repeatedly bringing attention back to the immediate situation

is a powerful antidote to the desynchronization of mind, body, and environment that originally fostered the mental disturbance (Podvoll, 1980). The patient is gently guided to apply these "contemplative" efforts in order to ground himself in the here-and-now.

> *Create open communication: Cultivate a style of honest interaction between the patient and his housemates to encourage "maitri" or gentle precision.*

The process of interviewing potential housemates accompanies the house search. Successful applicants must have a sane and orderly approach to their own household, practice a contemplative discipline, and have an overall allegiance to self-development or personal journey in all aspects of their life. Integrity and a sense of humor are considered invaluable assets. Generally, such applicants are as dedicated to learning as they are to earning a living. The patient and the team leader interview applicants, once again in the spirit of discovering a mutual working basis. When one housemate is selected, he or she joins the interview team.

The thorough precision of establishing the household may be experienced as mundane, tiresome, or boring by the patient or housemates, especially in contrast to the "life and death" issues that have brought the patient into treatment. One patient stated that: "[I] already know all about housekeeping. In fact, my mother was a perfectionist around the house and, in teaching me everything she knew, contributed to my obsessiveness. What I really need to figure out is the meaning of life and then to decide if I should bother with a clean home at all." The challenge is to discover a sense of profundity, in relation to the household and to establish the working basis of a "domestic discipline."

Much of the MPS approach is based on the Shambhala tradition. Chögyam Trungpa described two central themes of the

Shambhala tradition—the "heaven principle" and the "earth principle"—as follows:

> Traditionally, heaven is the realm of the gods, the most sacred space. So, symbolically, the principle of heaven represents any lofty ideal or experience of vastness and sacredness. The grandeur and vision of heaven are what inspire human greatness and creativity. Earth, on the other hand, symbolizes practicality and receptivity. It is the ground that supports and promotes human life. Earth may seem solid and stubborn, but earth can be penetrated and worked on. Earth can be cultivated. The proper relationship between heaven and earth is what makes the earth principle pliable (1984, pp. 129-130).

So, for example, the MPS view or theory that complete recovery from psychosis is possible (Podvoll, 1985) is an aspect of the heaven principle, whereas organizing and maintaining a household budget and ledger is in the realm of the earth principle. When properly joined, the heaven and earth principles result in the experience of being grounded and demonstrate the profound meaning of householding in human life.

In an MPS household the domestic ground is established with these principles in mind. First the house is rented and furnished, the patient and housemates move in, and food is purchased. Then increasingly familiar sights, sounds, and odors permeate the atmosphere. The patient settles into his new relationships with the team therapists and individual psychotherapist. The patient's and housemates' participation in proper exercise, adequate sleep patterns, and regular eating habits are gently attended to. A housewarming is held to mark the establishment of the new household. Guests include the entire MPS community, close friends, and the patient's family. These gatherings are often joyous and ignite a spirit of celebration.

DOMESTIC DISCIPLINE: BACK TO BASICS WITH ATTENTIVE RESPECT

> *Establish a schedule: Shared household meals, chores, and, especially, regular house meetings foster continuous sensitivity toward the well-being of the entire situation and accentuate the contrast between daydreaming and perceiving reality.*

The daily schedule begins to bring order to the activities of the MPS household residents. It becomes a crucial reference point which sharpens the residents' awareness of the boundaries of experience—for example, the boundaries between work and relaxation. House meetings are attended by the patient, the two housemates, and the team leader; they are held weekly at the MPS residence. These meetings serve as the central forum for managing household matters. For instance, chores which are shared equally and rotated among the household members, are assigned during these meetings. At least three meals are scheduled each week to be attended by all the house members; each member is scheduled to take a turn preparing the communal meal. The purchasing, preparation, serving, and cleanup of meals are discussed thoroughly. Initially, the dinner atmosphere may feel formal and strained—which may reflect a carry-over of tension from mealtime situations with the patient's family of origin—but it soon relaxes into an atmosphere of enjoyment. Hosting dinner guests becomes an opportunity to refine social graces and to extend generosity. Often team therapists participate in the cooking, dining, and housework in order to further enliven the household.

During the house meeting, the group frequently focuses on the quality of the relationships evolving among all the household members and, thereby, avoids excessive preoccupation with the patient. Some meetings begin with a "check-in" about how each resident's week has been or about current per-

sonal concerns that might impinge on the household atmosphere. The professional boundaries between the patient and housemates are openly discussed in these meetings rather than being unilaterally established. The patient is also encouraged to give feedback to his housemates concerning the fulfillment of their job responsibilities. For example, the patient might comment if one of his housemates is spending inadequate quality time at home due to social distractions or work outside of the household. In fact, the housemates' daily lives are an important source of vicarious learning and inspiration for the patient, although they may also engender a temporary depressive impoverishment in the patient if the contrast between the quality of his own life and the lives of the housemates is too great. However, the sharpness of this contrast can awaken further discrimination. The inevitable boredoms, irritations, and complaints that arise when people live together are ventilated in this atmosphere of honest communication. This may be an imposing challenge for a patient who has been previously isolated due to painful self-preoccupation with illness.

Honest, reciprocal communication between the patient, the housemates, and the other team members is the basis of consensus decision making and is at the foundation of the MPS therapeutic community. This kind of communication expresses our conviction that truth, itself, is medicine; that truth can heal. Chögyam Trungpa wrote:

> The main point is to tell the truth to your patients. Then they will respond to you, because there is power in telling the truth rather than bending your logic to fit their neurosis. Truth always works. There always has to be basic honesty; that is the source of trust. When someone sees that you are telling the truth, then they will realize further that you are saying something worthwhile and trustworthy. It always works. There are no special tips on how to trick people into sanity by not telling the truth (1983, p. 7).

In such an open social system (Jones, 1982), the patient has the opportunity to foster the personal and professional devel-

opment of the staff members and, thereby, exercise his innate compassionate impulses. The frustration of these compassionate impulses is itself a source of mental illness (Searles, 1979b). In this sense, the household is maintained for the benefit of everyone. This phenomenon of "mutual recovery" of staff members and the patient is the bedrock of any healing community.

Mutual recovery can be both a refreshing and confusing experience. The patient, as the person who is designated as ill, may want to relax into being cared for: having a maintenance crew to clean his house, having his meals prepared, or simply remaining in bed, and all the while secretly resenting being "babysat." These regressive tendencies are highlighted by the demands and attractions of ordinary daily life. R.D. Laing relates the story of a deeply regressed woman who, after several years of withdrawal at the Kingsley Hall community (Berke, 1980), actually got up from her bed of feces when she smelled the aroma of a delicious soup (personal communication, 1986). The patient's perception of contrast leads to a choice of whether to allow himself to slip back into the shadows of delusion or to face the bright world that surrounds him. Through this choice, the patient may begin to recontact a sense of appreciation and responsibility.

In turn, the MPS housemates may begin to wonder if they are therapists, friends, or, perhaps, even patients themselves! Not only are their personal domestic lives fully exposed to the patient and other team members, but their professional lives are also open to view and completely supervised. Regressive tendencies on the part of the housemates—such as treating the patient as if he is damaged, dependent, or like a child—are viewed as defensive. This kind of distancing serves to maintain a rigid sense of the housemates' role security and to ward off the threat of insanity—that is, both the patient's and the housemates' own insanity.

The difficulty of openly sharing the same environment and,

literally, breathing the same air with a patient in an acute or residual phase of mental disturbance has been unanimously attested to by the MPS housemates. At the same time, "breathing the same air" is actually the common ground of healing. The housemates are in the ideal situation to experience this because they maintain a twenty-four hour a day involvement with the patient's household. Chögyam Trungpa wrote:

> If you and the other person are both open, some kind of dialogue can take place which is not forced. Communication occurs naturally because both are in the same situation. If the patient feels terrible, the healer picks up that sense of wretchedness: for a moment he feels more or less the same, as if he himself were sick. For a moment the two are not separate and a sense of authenticity takes place. From the patient's point of view, that is precisely what is needed: someone acknowledges his existence and the fact that he needs help very badly. Someone actually sees through his sickness. The healing process can then begin to take place in the patient's state of being, because he realizes that someone has communicated with him completely. There has been a mutual glimpse of common ground (1985, p. 7).

In the context of such a direct relationship, the patient and the housemates are free to explore the true meanings of friendship and healing—questions that concern all of us regardless of mental illness. One may wonder whether such complete openness leads to wild, group indecency or whether the intimacy becomes too claustrophobic for the patient. One might wonder about the professional boundaries and ethics involved in the situation. Ongoing contemplative practice, training in compassion, and clinical supervision serve to maintain the housemates' awareness of their inner experience and the outer situation in the household. Good manners and basic human decorum follow naturally. The purity of the clinical intention is maintained when the patient's best interests are kept in mind. This is not to deny that strong emotions may occur among the residents, but these emotions can be worked with honestly. An MPS program "graduate" addressed this issue as follows:

> I think no matter how hard you try there will be a wall, there will be a distinction between therapist and client. It will be the "us and them" mentality, definite boundaries . . . . There [is] a definite barrier in the codes of professional ethics. Those walls are real, that's all I can say.

In contrast, a housemate described his experience this way after five months' work:

> I felt more relaxation within the formality of dinner. It was no longer just flat. I began to wonder: Who's providing what medicine for whom? for whose needs? mine? the patient's? I feel it's so good for me. . . . There's some dissolving of roles as we first thought of them . . . more fluidity of responsibility . . . more emptiness of roles, particularly of my healing someone. It feels so ordinary, three people living together, living their lives. There's more uncertainty about my role.

This particular experience was reported during a formal clinical presentation to a supervision group of housemates and team leaders. Presentations of this kind are detailed descriptions of specific domestic situations, which include the housemate's own experiential process. (Please see "A Contemplative Approach to Clinical Supervision" in this volume.) The supervisory discussion may focus on the housemate's well-being, his relationship with the other housemate or the patient, or simply the general decorum of the household. Gatherings such as these are important supportive components of the MPS community fabric.

> *Encourage a contemplative attitude: Cultivate recurring awareness of the basics of daily life. The MPS staff is brave enough to step beyond therapeutic aggression and the patient is brave enough to step beyond the nightmare of self-preoccupation. The techniques recommended for cultivating awareness are, for example, simply, sitting together quietly for several minutes before a housemeeting.*

As the treatment evolves, regressive tendencies that lead to

illness and professional ambition erode and honest communication and precision with domestic details gather strength. Trustworthy kindness that can accommodate potential chaos pervades the household. This is what is meant by the term *maitri*, or loving kindness:

> The basic point is to evoke some gentleness, some kindness, some basic goodness, some contact. When we set up an environment for people to be treated, it should be a wholesome environmental situation. A very disturbed or withdrawn patient might not respond right away—it might take a long time. But if a general sense of loving kindness is communicated, then eventually there can be a cracking of the cast-iron quality of neurosis: it can be worked with. This can be arduous. But it is possible, definitely possible (Trungpa, 1983, pp. 9-10).

The actual means by which a wholesome situation can be created involve bringing compassionate discipline to the elemental conditions of the household, such as money, food, and shelter.

This is a worthy challenge for the "warrior-healer." "Warrior," in this sense, has nothing to do with aggressive treatment of an enemy—of a disease syndrome—rather it means to overcome aggression itself. Aggression is the tendency to hold oneself intact in order to ward off any genuine contact with the situation at hand. Chögyam Trungpa defines a warrior as "one who is brave. . . . The fundamental aspect of bravery is being without deception" (1984, p. 108). A "healer" is simply someone who attends to another person's recovery of intrinsic health. A "warrior-healer" then, is a person who joins bravery and compassionate attentiveness.

One subtle form of therapeutic aggression that is inevitably faced in any treatment program concerns overly conceptualizing or psychologizing about the patient's alleged illness. For example, the therapist may pigeonhole a patient in a diagnostic category, or regard temporary mental disturbance as a chronic, fundamentally destructive suffering, but may ignore the history of sanity (Podvoll, 1983). The result is that the

therapist thinks of himself as a rescuer or savior, but is actually a self-righteous "dedicated physician" (Searles, 1979a). My own experience of this subtle therapeutic aggression is described in the following excerpt from a journal I kept during an eight-month period as an MPS housemate:

> I am in the middle of working with domestic irritation/anger/aggression and my tendency to distance from S [the patient] *is* aggression. I point out to him that he is crazy in these ways and he responds, "You don't understand! This is real and spiritual!" I try to put S in his place as the patient and myself in my proper place as the bastion of sanity to keep myself intact? The more fixed ideas I have about myself or S the less fresh air and ventilation there is in the environment."

The therapist begins to feel a certain arrogance and political dominance in this situation, which can lead to endless abuse of power. The therapist's attitude can influence his perceptions and clinical action and become self-reinforcing. This attitude leaves little breathing room for the natural unfolding of the patient's process of recovery of the basic state of health temporarily obscured by mental disturbance. The practice of the warrior-healer is to step beyond this therapeutic aggression into a genuine relationship with the entire situation. This is the personal practice of all the MPS team members but, in particular, of the housemates, because their lives are so embedded in the therapeutic household. The understanding and adoption of this practice is one of the objectives of the Master's Program in Contemplative Psychotherapy at The Naropa Institute. That objective is stated as follows in *The Naropa Institute Institutional Self-Study Report* (1986): "To teach students to recognize that there is no difference between personal and professional integrity and that an essential part of being a psychotherapist is to manifest health in one's personal life." Essentially, this means to regard all the different areas of one's life—personal, social, professional, spiritual—as a common training ground for developing awareness and compassion. To

relate to the rugged elements and vicissitudes of daily life in this way is to adhere to "domestic discipline." Chögyam Trungpa affirmed this:

> Enlightened society must rest on a good foundation. The nowness of your family situation is that foundation. From it, you can expand. By regarding your home as sacred, you can enter into domestic situations with awareness and delight, rather than feeling that you are subjecting yourself to chaos. It may seem that washing dishes and cooking dinner are completely mundane activities, but if you apply awareness in any situation, then you are training your whole being so that you will be able to open yourself further, rather than narrowing your existence. . . . Shambhala vision is based on living on this earth, the real earth, the earth that grows crops, the earth that nurtures your existence (1984, p. 97).

Strengthening maitri: Appreciation of increasingly clear sense perceptions grows in the domestic setting. A gentle, truthful approach to human intimacy causes truth to become medicine for bewilderment.

In order to meet the "meditation-in-action" challenge described in the previous section, MPS has utilized mindfulness-awareness meditation. In this meditation practice, one assumes an upright posture and places one's attention on the breath. (For a more complete description of this technique, please see "The Meeting of Buddhist and Western Psychology" in this volume.) The discipline trains one to bring one's wandering attention back from daydream to awareness of the immediate environment. The patient is offered instruction in mindfulness-awareness meditation at an opportune point—either when the patient has requested instruction or when the staff believe it would be appropriate. It is important to note that the essence of the meditation practice has already permeated the MPS household setting through the continual reminders by the team therapists to synchronize mind, body, and environment in ordinary activity. The intent is to awaken

the patient's mind through his sense perceptions and to establish an appreciation of the actual situation at hand. This sheds light on the true meaning of the ubiquitous folk saying, "Come to your senses!" This contemplative approach has been especially useful when withdrawing patients from psychiatric medications; it provides an alternative means by which to clear and stabilize the patient's attention.

It is this contemplative approach that sets a tone of gentle precision in the MPS household and in the entire treatment setting. Further domestic learning occurs because situational and interpersonal feedback is more clearly perceived by the residents and simple cause-and-effect situations become obvious. For example, food preparation, serving, eating, and cleanup skills become naturally refined and appreciated when household members pay more attention to them. Household meals become celebratory gatherings to which everyone contributes. The entire household situation becomes nourishment, in the larger sense, by supporting the residents' basic health and personal growth. The patient begins to make friends with the experience of being at home in his body on this earth. This experience is in poignant contrast to the common psychotic suspicion, "Maybe I'm from another planet." For instance, one patient stated, on entering the MPS program, that one of his main goals was to create and maintain a household and to learn to live with others after years of "solitary mind sailing." He has now accomplished that goal.

DOMESTIC HARMONY: CRISIS AND RELAXATION

> *Host the circle of friends: radiation of hospitality is essential, whether in welcoming guests to household meals or in hosting the attendants of a disturbed house member. Expand the virtue of the household through the practice of compassion.*

The term *domestic harmony* is prone to unrealistic interpretations. One might think it means creating a heaven-on-earth to achieve domestic bliss. To another the term might mean maintaining "walled in security" from the hostile, demanding world of the workplace. To a third person, domestic harmony may imply a license to establish a kingdom of personal territory, as in the expression "a man's home is his castle."

From the point of view of environmental treatment, domestic harmony means maintaining a decent, organized household that welcomes and supports wholesome activity. As Chögyam Trungpa stated, the goal is to:

> [create] harmony in your environment in order to encourage awareness and attention to detail. In that way, your physical environment promotes your discipline of warriorship. Beyond that, how you organize your physical space should be based on your concern for others, sharing your world by creating an accommodating environment. The point is not to make a self-conscious statement about yourself, but to make your world available to others. When that begins to happen, then it is possible that something else will come along as well. That is, when you express gentleness and precision in your environment, then real brilliance and power can descend onto that situation. If you try to manufacture that presence out of your own ego, it will never happen. You cannot own the power and magic of the world. It is always available, but it does not belong to anyone (1984, p. 110).

It may seem unwise to speak of "power" and "magic" in the treatment of psychosis because that disorder often involves the megalomanic abuse of personal power (Podvoll, 1983). For instance, domestic violence erupts within the privacy of the home: personal power can be abused on one's home turf according to one's own law. The central issue is aggressive territoriality—of experience or of the household. The challenge to the warrior-healer is to create and maintain a healing environment that is in harmony with the natural laws of the Shambhalian earth principle. The MPS approach contrasts with the common Western therapeutic model, which is based on a rigid hierarchy, one-way observation and communication,

and the mystique of medical power. In the latter approach, authentic human intimacy may become a technical intervention, rather than a spontaneous occurrence.

When an MPS household is settled—that is, when respect for natural boundaries that promote basic health has been established—a "circle of friends" may be properly hosted. "Circle" implies containment and fluid communication; "friend" means someone who genuinely cares. In this case, the circle includes the MPS treatment team, friends and families of the patient and housemates, and members of other MPS households. In a larger sense, this circle of friends is analogous to any gathering of people who attend to the welfare of a sick person in their community. It is common knowledge that along with the dissolution of the extended family or clan in our Western society, the mental health industry has formed to provide human services. In spite of the community mental health movement, however, the mentally ill have been relegated to a lower class on the cultural fringe. Through the creation of a contemplative healing community, which regards the disturbed person as a valued member, MPS works to recover the folk wisdom of the extended family.

> *Accommodate order and chaos equally: a housemate in crisis is neither complained about, punished, nor excessively indulged. Appreciate the complementary nature of health and illness.*

Sometimes an MPS household enters a state of crisis. Perhaps the patient has become increasingly despondent and suicidal or is forcing a psychotic transformation that may culminate in transgressive actions that are dangerous or "beyond the law" (Podvoll, 1983). With the mounting intensity, the team's attention focuses on the household as well as on the patient. Under these circumstances, the household is kept especially neat and fresh. Plenty of aromatic, nutritious food

is prepared. Fresh flowers are often arranged. The housemates are relieved of some responsibilities so that they are better able to process the personal strain and frustration that develop from "breathing the same air" with the patient. Clinical supervision is provided more often in order to ventilate the feeling of claustrophobia and to strengthen the team's precision. An atmosphere of combined caring and alert accommodation prevails; the patient is not punished or humiliated by the staff for his "inappropriate" behavior. Speech is used skillfully to comfort the patient and to reflect back the simple cause-and-effect relationship of the patient's or team members' confused interactions. Protective measures can be taken if necessary, such as confiscating flammable materials, alcohol, car keys, or sharp objects. These measures protect the safety of the environment and minimize the patient's possible negative actions and their consequences; they are not intended as an attempt to dominate the patient's extreme state of mind. Major tranquilizers can be used to slow down the speed of the patient's thought process without obscuring his natural consciousness and, thereby, allow the interpersonal situation to relax.

The psychological intention of the team members is even more significant during a time of crisis because a highly disturbed person perceives with exceptional accuracy. Hypocrisy, fear, deception, and conflict among the team members can only serve to provoke further paranoia and acting out in the patient. For example, cycles of escalating aggression between staff and patients are commonly observed in traditional hospital settings.

Sometimes crises are resolved easily and other times with more difficulty; there is no magical antidote. In the MPS approach, the team practices its warrior discipline; it strives to maintain authentic, healing friendships with everyone involved and to give precise, loving care to the patient. The situation in an MPS household in crisis is analogous to the situation in any

household where a member is physically ill or has been injured. All of the family members or housemates are deeply affected. The issue is how the household members and community gather together to help.

Sometimes a person has to be allowed to be sick without making too big a mess. Recovery is not a linear process but an organic development of wakefulness, which requires patience with the interplay of health and illness. The team and the patient learn to persevere despite the highs and lows. In any case, it is only common sense to create a wholesome environment in which to care for someone who is ill.

> *Develop the patient's proper relationship to space: cultivate a sense of genuine presence in physical and interpersonal space by skillfully synchronizing mind, body, and environment. Remain grounded on the earth with attentive respect.*

A central symptom of mental illness is the disturbance of spatial relations (Chapman, 1966). This disturbance can occur in any spatial sphere: in the orientation of one's body in physical space; in communicating with others in interpersonal space; or in relating to the space of one's own imagination and projection. In *Hidden Dimension*, Edward Hall wrote: "Man's feeling about being properly oriented in space runs deep. Such knowledge is intimately linked to survival and sanity. To be disoriented in space is to be psychotic" (1969, p. 105).

In order to allow the patient to explore and develop spatial relations, MPS has utilized a technique based on Buddhist psychology, called *maitri space awareness practice*. This meditation practice involves lying in a particular bodily posture in one of five differently colored and shaped rooms while maintaining experiential awareness. Although the technique involved in this practice and its clinical effectiveness require further explanation, such an explanation is not within the scope of this article. However, we have found that the carryover to one's daily

life is increased appreciation of the senses and attentiveness to full-bodied presence in physical and social space. Chögyam Trungpa wrote:

> To communicate skillfully a person must be aware of interpersonal distance—a sense of whether he should reach out or wait. That kind of distance becomes very distorted so that communication is handled unskillfully; and there is frustration about that blindness. This brings on aggression and the demand for pain. . . . Because one becomes completely overwhelmed, involved, self-centered into so much *here*, one loses the distance. That is the extreme of egocentricity.
>
> It seems that setting up a certain kind of general situation for the person is more effective [than using encounter-group or analytical methods]. One starts with the basic physical situation of food and living environment. The whole idea of using the situation is to communicate with the unbalanced person so as to awaken him, so you start on the basic level of survival, the instinctive level, the level of the animal realm. The person should have some feeling of instinctive simple communication. Start that way. Then having established that kind of simple communication on the level of survival the rest become much easier and quite obvious (1978, pp. 71-72).

The outcome of domestic harmony is the patient's development of a proper relationship with the varieties of space that promote health. These include the physical and social space of the household as well as the open psychological space that can accommodate order and chaos, or health and illness. To protect this harmony, furnishings, interpersonal encounters, and concepts are simplified. The MPS housemates share a household with the patient, which is neither withdrawn from nor continuously engaged in therapeutic work. An almost palpable atmosphere of relaxation, precision, and hospitality develops in the domestic setting. This is often obvious to members of the housemates' families, who are encouraged to reside in the household during visits. It is this domestic harmony that hosts the circle of friends, and the wider MPS contemplative healing community. In this way, the patient is provided with an interesting and expansive healing environment in which the com-

plexities of chaotic mental disturbance can naturally unwind.

CONCLUSION

The key point in this presentation is that an appreciation of the sanity and goodness of the earth principle can be embodied in a therapeutic household. It is the ground, discipline, and harmony of a healing environment. Respect for and attention to the ordinary details of domestic life are a powerful antidote to mental disturbance, the root cause of which is the wandering of mind from environmental details. The MPS approach establishes the domestic environment as the cornerstone of a sane world. Future research in environmental treatment could begin with simply taking a fresh look at our own household.

> If we apply the perspective of heaven, earth, and man to the situation of the world today, we begin to see that there is a connection between the social and the natural, or environmental, problems that we are facing. . . . Human beings destroy their ecology at the same time that they destroy one another. From that perspective, healing our society goes hand-in-hand with healing our personal, elemental connection with the phenomenal world (Trungpa, 1984, pp. 130, 132).

SUMMARY: HOW TO ESTABLISH A THERAPEUTIC HOUSEHOLD

Domestic Ground: Earthy Practicality

1. Establish the household
2. Pay deliberate attention to details
3. Create open communication

Domestic Discipline: Back to Basics with Attentive Respect

1. Establish a schedule

2. Encourage a contemplative attitude
3. Strengthen maitri

Domestic Harmony: Crisis and Relaxation

1. Host the circle of friends
2. Accommodate order and chaos equally
3. Develop the patient's proper relationship to space

NOTES

1. In this article, the words "he," "his," "him," and "himself" will be used in favor of the more awkward phrases "he or she," "him or her," and "himself or herself."

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