THE WINDHORSE PROJECT: RECOVERING FROM PSYCHOSIS AT HOME

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The Windhorse Project for recovery provides individually designed and comprehensive treatment for psychologically disturbed persons in home environments. This innovative program is described by its founder, Edward M. Podvoll, M.D. in *The Seduction of Madness* (1990). This book presents a whole-person view of psychosis and recovery that is illuminated by firsthand reports and the author's clinical experience. Dr. Podvoll describes the methods of compassionate care, which involve a team of skilled therapists working closely with a disturbed person in his or her own home. The network of these individual treatment households, together with the households of the staff members, have come to form an extended therapeutic community. This community was initially established in Boulder, Colorado (1981) as Maitri Psychological Services and then expanded to Halifax, Nova Scotia, Canada (1989), as Windhorse Community Services. The primary treatment and study center of the Windhorse community is now located in Northampton, Massachusetts (1992), where the present author is the director of Windhorse Associates, Inc.

THE PRINCIPLES OF THEORY AND METHOD

There are four essential principles:

1. *Psychosis is a major disruption in the balance of the body-mind-environment system* that dislocates the person from the functional reference points of ordinary life. An effective treatment program must work with all of the imbalances in the biological, psychological, social, and spiritual dimensions of the whole person.

2. *Significant recovery is a real possibility* for anyone suffering in psychosis. The person's intrinsic intelligence continually inter-

rupts any psychotic turbulence with momentary experiences of insight and freshness that bring the person into more direct contact with his or her body and surroundings. This experience is a coming to one's senses, as if awakening from a dream. Such fragile moments are "islands of clarity" that must be recognized and protected as the seeds of recovery.

3. *Recovery can occur naturally when catalyzed by authentic therapeutic friendships* in a homelike setting. Grouping severely disturbed people together in one place of treatment may risk the health of both clients and staff. An ill person is likely to become healthier when in the company of other healthy people in a sane environment.

4. *A Windhorse treatment team attends* to the recovery of the client, and is also committed to the well-being of each team member, the client's family, and the entire therapeutic community. The traditional meaning of a healing community resides in this wide-ranging intention.

These principles, when contemplated and experienced in clinical practice, can arouse the cheerfulness and resourcefulness required to attend properly to someone on the arduous journey of recovery. This attitude is an antidote to the potential exhaustion of one's compassion and resources, and is embodied in the name "Windhorse" that we chose for our service and community:

> Windhorse refers to a mythic horse, famous throughout central Asia, who rides in the sky and is the symbol of man's energy and discipline to uplift himself. Windhorse is literally an energy in the body and mind, which can be aroused in the service of healing an illness or overcoming depression. (Podvoll, 1990, p. 24)

These principles translate into a comprehensive method of care that is simple and effective and has withstood the test of time.

The method of care used in the Windhorse program is home-based team treatment. The pattern and cost of clinical teams vary on a continuum of intensity, depending on what is needed and the available financial resources. Three primary components comprise an intensive team (a partial team is less elaborate): (a) *therapeutic*

household, with live-in housemate(s), is a home setting established as the locus of treatment for each client; (b) *basic attendance,* a specialized form of therapeutic relationship, is provided by a team leader and several team therapists; and (c) *intensive psychotherapy* is provided by a principal therapist in individual therapy sessions. In order to supplement the skills of the core team, adjunctive services may be useful. A psychiatrist most often joins each team to monitor medications or to provide psychotherapy. These components will be clarified in the clinical examples to follow.

A pattern of meetings, facilitated by the team leader and principal therapist, integrates the team's activities. These meetings include: the weekly team meeting of team members and client, which is of central importance; the household meeting in the home with client and roomate(s); the team leader's meeting with the principal therapist; the supervision meeting with team therapists; and family meetings with client and family members. If several therapeutic homes are in operation, then additional meetings include: a community meeting of all therapists and clients; an all-staff meeting; and housemate meetings of past and present roommates. These larger meetings are often held in team members' homes and provide opportunities to socialize together. This meeting pattern gives structural coherence to the treatment situation and avoids the fragmentation in care and impersonal relations often found in situations with multiple care providers. These meetings form a matrix of social containment, which is essential since there is no fixed facility to give physical boundary to the therapeutic environment.

The principal therapist and the team leader organize the household and the team. They assess the client's needs, capacities, and available financial resources, in consultation with the client and family. An affordable treatment prescription is then tailored to the client's situation by combining more or less of each of the primary and adjunctive components and the types of meetings. Such a design is adaptive to the uniquely evolving situation of the client, and future adjustments are made in collaboration with the client and family. Each team is intended as decremental in size and cost over

time, although the client's social involvement with the Windhorse therapeutic community is encouraged after formal treatment has ended. We openly acknowledge the possibility of significant recovery but do not predict the degree or direction the recovery may take. In practice, we commit ourselves to be in empathic contact with the client's present condition and life situation.

The forms of a Windhorse team are as varied as the range of clients' unique life situations. Our experience has shown that the most stable recovery from psychotic imbalance occurs in the familiar surroundings of one's home, attended by gentle companions.

THE CLINICAL NARRATIVES

One intensive team is extensively presented and two partial teams are briefly described to illustrate the principles of the Windhorse theory and method. Consideration has been given to confidentiality.

An Intensive Team: Jonah

I was referred by a colleague to the director of the rural treatment center in Europe where Jonah had been a resident for three years. Jonah had made progress recovering from a disabling chronic schizophrenia and was now able to perform minimal tasks of daily living and to communicate with others. The director and Jonah's family felt that a highly structured therapeutic environment in an urban setting would foster his maturity. Jonah wanted relief from a relentlessly tormenting "voice" that for five years had caused "heavy feelings" in his "soul." He also wanted to live independently and to visit India someday.

I contracted with a team leader and we negotiated program cost and design with Jonah's parents and the referring director. We invited Jonah to visit us for a week in Nova Scotia for a "mutual interview" (see Fortuna, 1987). Prior to the visit, a psychiatrist, three team therapists, and a potential housemate joined us to form the initial team. The primary hiring criteria for team members are

whether they are willing, capable, and available to fully participate in the team. In particular, a key question that I ask myself when considering someone is, "Would I want to be with this person if I were ill and unable to care for myself?" We held several meetings to prepare ourselves for the visit and to design a schedule of clinical and social events that would give Jonah sample experiences of the program. I shared with the team what I had already learned about Jonah, emphasizing equally his histories of sanity and illness (Podvoll, 1983). I took special care not to burden the team with too many preconceptions prior to our meeting Jonah. This began the subtle process of the team finding its unique rhythm and emotional spectrum in relation to Jonah, which is analogous to an orchestra tuning itself prior to a concert. During the visit, Jonah expressed—in spite of his withdrawal and his difficulty with English—his desire to be free of the "voice" and to be more independent. Jonah was appropriate for our program because he was nonviolent, was able to spend time alone safely and relate to a schedule, was personally motivated to come, and because his cognitive ability and talents were intact.

Jonah presents himself as a self-absorbed man, 30 years of age. His current therapist informed us that Jonah often inspires other people to feel affection toward him even though he offers so little of himself in return. Jonah's face is obscured by brown, bushy eyebrows, full beard, and long hair that drapes his cheeks and neck. His skin is pallid and lackluster. His stocky frame of medium height is slouched and rigid, with atrophied muscle tone. Jonah tends to neglect personal hygiene, and his dark-colored clothes are unkempt. If left alone, he sinks into himself in bed for long periods. He can exhibit a surprising precision in the way he handles an object or shakes someone's hand. He mutters semiaudibly to himself in a snarling, exasperated tone (in his mother-tongue), "Let me alone! Go away! It's all bullshit!"—although he explains that this is the "voice" speaking through him. He has an addictive preference for caffeine, nicotine, alcohol, or street drugs, which intensify his symptoms. He has been relatively stable for the past two years on

4 mg of Haldol per day, although he is unhappy with the drug's side effects. Jonah's eyes are clear gray-blue, the gaze most often downcast and fixed, though he often makes prolonged, startling eye contact. My first reaction is often to feel ensnared by his gaze, then frozen in a helpless sympathy. After long moments, he and I usually smile together, exchange a few words, and look away. This contact illuminates Jonah's aura of angry impenetrability and conveys the impression of a person of significant depth of feeling and intelligence who is both drawn to and terrified of human relationship.

The program:

1. Household: Jonah resides with a male housemate in a rented, modestly furnished two-bedroom home in a quiet residential neighborhood during his 14 months in Nova Scotia. The housemate needs consciously to relax his therapeutic ambition for Jonah's improvement, allowing them to be more "down home" together as ordinary roommates. This relaxation of strict professional boundaries in the direction of genuine friendship characterizes the Windhorse approach in general and is fostered by each team member's practice of "asylum awareness" (Podvoll, 1990). This is a practice involving momentary recognition of one's tendency to exert therapeutic power over others as an unconscious reaction to one's own anxiety or bewilderment.

> Contact with insanity tends to provoke "asylum mentality": a reflexlike way of responding to insane people that can, in a moment, generate all the notoriously punishing techniques of treatment used in a supposedly bygone era. Even in the most benevolent of institutions, asylum mentality erupts as a series of self-deceptions and primitive beliefs, or superstitions, about what madness is and how it should be treated. (Podvoll, 1990, p. 62)

Recognizing this tendency frees one's basic attention from fear and fixation and brings one's presence back to the immediate experiential field of self, other, and situation. This practice of asylum

awareness functions as a contemplative discipline in an interpersonal context.

The housemate and Jonah spend several hours together each day in domestic living, sharing responsibility for housework and cooking. Weekly household meetings are facilitated by the team leader to review necessary chores, the arrangement of the environment, the household budget, relationships between house members, and plans for hosting guests. Naturally the dirts of soiled air and floors, of unspoken resentments, and of depression accumulate in the environment. However, we remind each other of the slogan, "Train in cleaning up after yourself," as a bedrock ecological effort for maintaining a decent household.

2. *Basic Attendance:* Four team therapists and the team leader individually attend to Jonah during three-hour shifts in his home and in the field. Two shifts are scheduled each weekday, and each weekend day has one six-hour shift, allowing for leisurely excursions into the countryside. On this particular team, the therapists all hold Master's degrees in clinical psychology and have extensive clinical experience. They also practice a formal type of mindfulness-awareness meditation which reveals the common tendency to be absorbed in habitual patterns of thinking. This experience allows the therapists deeper empathy with Jonah's entrapment in mental projection. Mindfulness-awareness practice provides the therapists with personal knowledge of how one's body and mind can be joined and synchronized, which is also the intent of basic attendance. This practice also serves as the basis for the interpersonal practice of asylum awareness. The quiet household setting provides opportunities for team members to attend to Jonah by gently encouraging him to refocus his distracted attention on the sensory details of ordinary activities. By practicing these "domestic disciplines" (Fortuna, 1987), Jonah strengthens his concentration and knits his mind, body, and environment more closely together. Contemplative practices are relied upon by increasing numbers of therapists to coordinate body and mind as the foundation of their

personal health and of the healing relationship (see, for example, Kabat-Zinn, 1990).

Four adjunctive team members have weekly contact with Jonah: a language tutor, an acupuncture and massage practitioner, and a psychiatric nurse and a psychiatrist who both monitor Jonah's medication and general health. Each adjunctive person attends a team meeting monthly.

3. *Intensive Psychotherapy (IP):* As the principal therapist, I meet with Jonah during four one-hour sessions per week in the formal setting of an office. IP is a specialized form of basic attendance rooted in the tradition of Edward Podvoll, Harold Searles, Otto Will, Frieda Fromm-Reichmann, and Harry Stack Sullivan. In spite of the volumes written and the years of oral instruction given, IP with highly disturbed persons seems an "endangered species" in all but the most elite psychiatric hospitals. The basic premise of IP is that human intimacy is a significant catalyst for recovery from psychosis. The activity of IP is to cultivate an authentic therapeutic friendship. *Authentic* means to recognize that empathy with the client's experience happens naturally as the starting point. *Therapeutic* means to search for and give proper voice to the truth available in every interpersonal moment. *Friendship* means that client and therapist become trusted companions who encourage each other in a process of mutual learning. In the Windhorse approach, the principal therapist is just one element in an integrated treatment network, rather than the single point of meaningful therapeutic contact.

The root interpersonal discipline of basic attendance can appear to be deceptively simple in its focus on ordinary daily activities and on simply being with Jonah. There are many degrees of sophistication in properly attending to the intricate function of synchronizing mind with body and environment without forcing a particular outcome. It is the concerted effort of the group of people who practice basic attendance—with the client and with each other—that constitutes the work of the healing team. This is not a conventional multidisciplinary group of specialists, such as a psychiatrist, social

worker, nurse, and so on, who sometimes consult together about their individual work with a client; rather, it is a team that is facilitated by on-site leaders (internally accountable) and whose members are openly responsive to each other and to the task. This style of working team can increasingly be found in the most successful business and political organizations worldwide.

The team leader and I co-lead the weekly team meetings and individually supervise team members. I maintain bimonthly phone contact with Jonah's father, who becomes a close collaborator in the treatment. My work with Jonah's team is ten hours per week. The team leader works 15 hours a week supervising the household and especially the housemate, and tracks the details of program budget, schedule, and case management. She and I are continuously available by phone to the team.

The cost of Jonah's program is $300 per day. This provides flexible and comprehensive treatment for Jonah's unique life predicament in his own home, far below the cost of hospital care.

The journey of treatment: The daily schedule provides a predictable structure that safely moves the healing environment forward. "Schedule is related to rhythms, cycles, number, counting, the pacing of things, and the movement of seasons" (Podvoll, 1990, p. 261). The very fabric of human life is a dynamic pattern of rhythms that is in or out of balance internally and with the environment.

> Just how the neurotransmitters affect the mind itself is unknown. But everything indicates that they affect the rhythms of the brain and the rest of the body. . . . Everywhere there are patterns and rhythms of activity. There are menstrual cycles, breathing rhythms, heartbeats, and cellular oscillations; even the microparticles (known as organelles) inside each cell have been found to be rotating and vibrating. Every particle of human life is involved in the musical activity of producing rhythmic waves of energy." (Podvoll, 1990, pp. 184-185)

The precision of the schedule sharpens Jonah's and the team members' awareness of the boundaries of experience, such as between work and relaxation, or between daydreaming and attending to the situation at hand. To be alone for long periods drifting into the future is unhealthy for any person recovering from psychosis,

especially from the negative symptoms of lack of motivation, blunted affect, and social withdrawal. Constant attention to the sane rhythms of schedule is the background of our work with Jonah. This balancing and integrating of the rhythms of the client's body, mind, and environment is a primary Windhorse medicine.

The weekday schedule for Jonah is typically as follows.

8 a.m.: Jonah awakened by housemate or alarm, tries to dress and attend to hygiene.

9 a.m.-noon shift: Team therapist helps Jonah with dressing and hygiene, if needed, and tidying bedroom; the two prepare breakfast, eat together, and clean up; Jonah takes medication; reviews daily checklist for morning routine; does preassigned housechore with team therapist; remains at home or engages in an outside activity such as walking, shopping, or going to the library, a café, or a class; rides bus alone to IP appointment.

12-12:50 p.m.: IP session.

1-1:30 p.m.: Rides bus or walks home alone.

1:30-3:30 p.m.: Attends language tutorial or session with acupuncture/massage therapist, or rests at home alone.

3:30-6:30 p.m. shift (less structured than morning shift): Engages in an outside activity with team therapist; remains at home and converses, reads or listens to music; prepares dinner, eats, and cleans up with housemate; takes medication.

Evening: spends time with housemate or alone; goes to bed after dinner or stays up later (regular bedtime encouraged).

1. The First Spring. The fresh beginning with Jonah's arrival is reflected in the bright skies and flowers of spring. The team attends to the practicalities of establishing the household and to developing rapport with Jonah. We gently urge Jonah to participate in spite of his well-honed resistance to intrusion by us or the "voice." Team members feel frustrated and rebuffed, even hurt, by Jonah's refusal to "let us in." Each person, with word, touch, or gesture, begins gently to call Jonah's attention back from distraction. We observe that Jonah compulsively eats unprepared food, smokes cigarettes, paces, mutters incessantly, and lies prone for long periods drifting

in and out of trance, dream, and sleep. We soon discover an irregularity in Jonah's cardiac pulse for which a medical exam shows no obvious physical cause. We observe that Jonah's diet revolves around the stimulants of nicotine, caffeine, alcohol, and sugar. We notice that his speed of mind and self-absorption intensify the more he ingests these substances. Organizing healthier life rhythms becomes our first priority. We intervene by tightening our control of his pocket money, keeping healthier foods in the household (such as decaffeinated coffee), and showing Jonah wholesome alternatives. We keep a warm pot of bancha tea, the great "balancer" in the macrobiotic system (Podvoll, 1990, p. 230), on the stove during the day, which Jonah and all staff are encouraged to drink. We encourage more regular exercise, reduce the haldol by 50%, and introduce Jonah to weekly acupuncture and massage. Jonah alternates between passive compliance and stubborn resistance to these changes in lifestyle. The team acknowledges the risks of this exercise of therapeutic power, including, for example, possibly reinforcing Jonah's sense of persecution and powerlessness in dealing with the "voice" or any other real or imagined forces beyond his control. We explain to Jonah the practical necessity of such protective boundaries and that our primary intention is to encourage his personal motivation and independence. We listen thoroughly to all of his objections concerning his restricted freedom. Jonah's English is barely adequate, which further strains interpersonal contact, increasing his sense of alienation. The concerted efforts of Jonah and the team to learn each other's languages become the tangible model for establishing a deeper level of communication through his isolation and our alienating feelings of frustration and impatience. Language dictionaries are kept close at hand.

The task for the IP sessions is for Jonah and me also to learn to communicate meaningfully. We settle down in long silences and often share a cup of tea. I soon realize that I must abandon any strategies to change or rescue Jonah in order to truly listen to him. When I notice my mind wandering, I acknowledge what relevance my distraction, whether daydream or feeling, might hold in relation

to Jonah, and then gently bring my attention back to the rhythm of breathing, physical posture, and a general awareness of the room. Frieda Fromm-Reichmann (1959) taught that the one prerequisite for all intensive psychotherapy is that "the therapist must be able to listen . . . in this other person's own right" (p. 65). IP is a controversial aspect of the Windhorse approach. Most psychiatrists with whom I spoke assured me that such intensive therapy is too stimulating for the fragilely defended ego; is an anachronism now that we have biomedical science and neuroleptics; has not been shown by research to be of benefit; is not cost-effective; and has only been useful in elucidating psychotic phenomenology. Critics often fail to appreciate that IP acquires unique value when practiced within an integrated therapeutic team. I am also faced with personal fears that nothing is really happening, or that I am not trained enough to deal with transference issues, or that too much time and money are being spent on just sitting together. During a session, Jonah, with a word or glance, draws me out of these moments of doubt back to our relational space. Jonah is always on time for our sessions and we both value our time together.

In our sessions, Jonah and I begin to investigate his suffering, especially his experience of the "voice," in detail. His sane doubts are slight but they occasionally pierce his delusional conviction in the "voice." Relating directly with such moments of doubt as islands of clarity, in either the therapist's or the client's experience, is a cornerstone discipline for the recovery from psychosis and of IP itself (Podvoll, 1990, pp. 25-28). Jonah's involuntary muttering and snarling soon come to dominate our sessions. In response, I introduce an exercise that we repeat frequently over the next three months: Sitting side by side, we focus our attentions on a clock for two-minute intervals and hold our mouths closed, breathing normally. During the exercise, Jonah's mouth is unmoving and he reports, to his surprise, not hearing the "voice." Later the practice is transferred to the basic attendance shifts and the interval extends to five minutes. Eventually, Jonah learns to hold his mouth still

and to stop the "voice" for several minutes at will, enabling him to stabilize and extend these islands of clarity.

In the second month, we celebrate Jonah's birthday, the team leader's new pregnancy, and a housewarming at the household with the team members' families. Jonah's anxiety and repressed anger are becoming more apparent, and we have a healthy respect for how he might eventually express his emotions.

2. *The Summer.* This is the season of growth and activity. Jonah becomes more alive to the world around him, evidenced by a flushed complexion, robust movements, and clearer eyes. He briefly attends pottery lessons, where he angrily pounds clay and smashes discarded pots. Often he is in a rage with agitated, restless movements and is occasionally sleepless. Team members experience sharper alternations of being in and out of contact with Jonah. The structure in the household is increased concerning, for example, Jonah's being fully clothed at home and not smoking in his bedroom, which further irritates him. The housemate becomes uneasy and he and the team leader are in conflict. The housemate gives notice that he will resign in the fall and we begin to doubt our decision to staff the household with only one roommate. The situation seems directionless and potentially unsafe, and this seems to mirror Jonah's experience. The team bands more tightly together by emphasizing precision of schedule and communication.

The tension builds prior to Jonah's parents' week-long visit to Nova Scotia in the fifth month. During a team meeting with Jonah and the parents, we agree that Jonah is waking up in the middle of his psychotic nightmare with no apparent means of escape while experiencing his pain more clearly. Jonah's mother explains that he has been at this point on three past occasions, "but he always ran away before and now he cannot run away." His parents cannot agree to his request to live with them; he becomes increasingly agitated. We discuss with Jonah what he needs now in his life. We agree to allow him to smoke in his room if he uses an air purifier and smoke alarms; to have freer use of pocket money; and to begin to plan a vacation for himself and a team member. Jonah's mother

states that "a person must have a vision," and if Jonah's is to visit India then we could build on that interest in every imaginable way. Later, we gently encourage the parents to abandon feelings of guilt at having failed as parents. We emphasize that their present mental health has a positive impact on Jonah and the team. The morning of their departure, Jonah is very sad and despondent, his eyes welling with tears. Long gazes between Jonah and team members seem laden with loneliness.

3. *The Autumn.* The pace of summer slows to the cool season of harvest. Jonah becomes more withdrawn and depressed, and begins to ignore the schedule. This regression coincides with his parents' departure, the roommate's termination, a change in language tutors, and the team leader's increasing preoccupation with her pregnancy. Jonah's Haldol is increased and Valium is prescribed. Over the 14 months of treatment, Haldol is adjusted across a range of 1–5 mg/day, and Valium is adjusted across a range of 5–20 mg/day. This treatment has a positive effect, which is reinforced when a roommate of Jonah's age is hired. The new roommate has a natural affinity for being with eccentric people and is a student of the healing arts. Soon after moving in, the roommate reveals, to our surprise, that he is four months into his recovery from severe drug abuse. The team members become trusted elders to him and he grows significantly over the next year. Jonah's and the roommate's parallel journeys of recovery serve to strengthen their camaraderie.

Jonah becomes curious about the smallest details of things, whether the name and origin of a particular tea or the place where a team member grew up. He begins to anoint himself with a fragrant cologne and to enjoy luxurious bubble baths. He attends the cinema with steady attention and resumes the weekly swimming lessons he had begun the previous summer. He begins to report that the "voice" can now "taste what I taste, hear what I hear, feel what I feel." This may be a beginning reintegration of Jonah and the projected "other." We begin to remind Jonah of decent manners, such as in addressing other people or in eating a meal. Behaving

with respect towards one's environment uplifts a person from the obliviousness that degrades body and mind.

But by December's end, Jonah shows increased psychotic agitation and withdrawal, feeling the emptiness of the holidays away from home. He spends Christmas day at my home with family and friends, remaining anxiously withdrawn on the periphery.

4. The Winter. The sun is at its lowest point and Jonah longs for a warmer, brighter climate. His frustration and loneliness mount to an acute psychotic episode. One morning he has a barber cut his beard and hair short, and his muttering and movements become pressured in an explosive buildup. In our IP session, I am shocked to see his face so exposed, as if he has suddenly emerged from hiding. He insists that his loneliness is intolerable and that he must return to his native country. I am unable to slow the escalation. Later in the day, he vigorously punches the air around him, plays rock music loudly, and makes unintelligible sounds that frighten his roommate. On an accompanied walk, he pushes a female pedestrian against a parked car because "she is Canadian," he later reports. She is stunned but unharmed. I meet at the household with Jonah, who is now shaking in bed fully clothed. I offer him enough medication to reestablish contact. He reiterates his desire to return home and I agree to consider this immediately. We remain quietly together into the evening.

The crisis subsides overnight. When Jonah rouses from a long, deep sleep we find his cognition stable, his interpersonal contact excellent, and his motivation to continue with the program unambivalent. The crisis seems to be a personal drama intensifying to a breaking point, followed by a prolonged island of clarity. The team regards this as a healing crisis. The meaning of the event includes not only Jonah's manifest experience of missing his native language, land, and family, but also his coming into direct contact with his profound loneliness accumulated over years of social withdrawal.

Regarding a psychotic crisis as potentially healing is a mark of an alternative to the conventional medical model treatment. The

crisis may not be the symptomatic recurrence of a disease once held in remission, requiring suppressive measures for a person to recompensate back to a previous level of functioning. Rather, this may be a crisis of organismic growth initiated by chaotic disintegration of a previously stable state. The crisis is healing if the person reintegrates to a more evolved level of meaning and function, and is destructive if the psychotic disturbance intensifies towards further chaos, injury, or death. The outcome is significantly affected by how one is treated by others, and how the person relates to the spontaneously occurring islands of clarity experienced as gaps of doubt and wakefulness in the pressure of the crisis. Gregory Bateson has proposed the notion of a "curative nightmare"—"that the body or mind contains, in some form, such wisdom that it can create that *attack* upon itself that will lead to a later resolution of the pathology" (Bateson, 1961, p. xii). Persons in the patients'-rights movement insist that mental health professionals first consider a psychotic crisis to have growth potential before altering its vulnerable transitional states with involuntary treatments.

Jonah begins to describe openly his depression as "heavy, dark feelings in the soul" which alternate with bright moments of sunlight or the companionship of women. He vacations in Mexico with his roommate, curbs his overeating, and reduces his cigarette smoking, all of which make him "feel better and the 'voice' less difficult." Medications are again reduced. Jonah enters a work-oriented day program for disturbed persons and shows surprising skill in long-neglected hobbies of chess and backgammon. He shows more concern for the team members, frequently offering tea on shifts. A major focus for the remaining months becomes learning the skills of conversation. We begin planning for Jonah's departure, although it has been decided, with Jonah's input, that he will remain for two additional months.

5. *The Second Spring.* The cycle of the seasons is completed. The team relaxes the program structure, giving Jonah more responsibility. For example, having unsupervised pocket money communicates that he can care for himself. Increasingly he is attentive to his sur-

roundings and makes poignant attempts at conversation. He is "coming out" with the tentative awkwardness of one emerging from a harrowing inner ordeal. The team members express sadness as our team community prepares to disband. Jonah will join a partial Windhorse-style team in a familiar European town accompanied by the current roommate, who will continue to live with him. By telephone, the parents express their gratitude for the opportunity that the Windhorse group has provided Jonah, although the father expresses his doubts about whether Jonah has really changed. It is revealed that when Jonah speaks with his father by phone he lapses into agonizing complaint about his condition, even if he is otherwise having a good day. Jonah explains his notion that if his father knows how bad he feels then perhaps he can help him and even accept him back home. He also expresses an old grudge he has harbored for his father's having forcibly removed him at age 16 from the family home to a psychiatric hospital. I suggest to Jonah that he is old enough and well enough to assume personal responsibility for his experience, and that it is now time to unburden others, especially his parents, from his pain. He considers this and smiles enigmatically, leaving me uncertain of his meaning.

A weekly team meeting occurs the day before a second birthday celebration for Jonah, two weeks before he is to leave Nova Scotia. His psychotic turmoil has intensified over the past 48 hours. Amid forceful vocalizations and facial contortions, he complains of the relentless torture of the "voice," of his inability to do anything for himself, and of his wish to die. The team offers him empathic reassurances and the obvious termination-anxiety interpretation to no avail. He insists that we do not understand him, nor he us, and that there is no hope for him. With no way to bridge the abyss with Jonah, the team doubts its work of the past year. I remember, with some comfort, that at the end of anyone's treatment, the entire original problem often recycles as if nothing useful had happened. I decide to delay sharing this conceptual interpretation, as I feel to do so would drain the life out of this poignant group experience. The meeting ends with no resolution.

The following morning Jonah is pleased to awaken to birthday phone calls from both parents. The birthday celebration is a communal island of clarity, alive with music, children's voices, and good cheer that eases our previous day's struggle with isolation. Jonah responds with smiles to the thoughtful gifts and affectionate farewells he receives.

After 14 months together, the team meets at the household. A photo album of Jonah and the team is presented to Jonah. Final goodbyes and good wishes are exchanged, and then it is time for Jonah and the roommate to go. The team stays for a final cleaning of the house, and then disbands.

I have remained in contact with Jonah, his parents, and the roommate in Europe. Jonah continues his slow, steady recovery in the context of a small therapeutic team and household. He and his roommate have plans for the long-sought visit to India. Jonah's parents and others who knew him before the Windhorse experience acknowledge his improving health.

A Partial Team: Rich

Rich's parents were referred to our service by a psychiatric hospital where Rich, age 30, had been a patient for two months and was soon to be discharged. He had been removed by the authorities from his parents' home and taken to the hospital during an acute paranoid episode of a disorder previously diagnosed as "schizoaffective." After meeting with the hospital, the family, and Rich, I agreed that Rich would live alone in an apartment supported by social assistance, and continue under the care of his psychiatrist of seven years, to be paid by medical insurance. A team leader, myself as the principal therapist, and three team therapists would comprise the therapeutic team. Rich would learn to live independently by developing his interests, a career, and a social life outside of the family circle.

Once the team began its work, each team therapist and the team

leader met with Rich twice per week for the three-hour shifts of basic attendance, totaling eight shifts per week. Rich spent Sundays at his parents' home. I met with Rich for two weekly sessions of individual psychotherapy, and joined Rich and his psychiatrist monthly to discuss medications. The psychiatrist, cognizant of the danger of tardive dyskinesia, had been eliminating Rich's Haldol and phasing in Buspar, an anti-anxiety agent. I met weekly with the team leader for planning and supervision, and we met monthly with Rich's parents, most often including Rich. Supervision of the team members occurred in team meetings and by phone. The cost of the service to the family began at $130 per day, decreasing to $30 per day currently as Rich's capabilities have strengthened. These figures do not reflect housing and psychiatrist costs. My departure and that of another team member reduced the team's size and cost, and transferred more responsibility to Rich. He continues to attend the weekly hour-long team meetings, now more central to the integration of the smaller team.

A key clinical issue has been Rich's proper emancipation from home. During his recent "paranoid episode," Rich reported he actually was barricaded in his bedroom to give him the privacy to plan how to move out, while his parents were privately discussing the same matter. There has been no overt sign of psychotic disturbance since Rich began with the team. A year later, Rich has become a trusted elder in the family matrix, modeling the process of leaving home for the younger siblings. The family has matured and Rich has discovered the necessary courage to relate more truthfully with himself and others. In spite of his shyness, Rich has become an active participant in the Windhorse community meetings. Rich is not as disturbed as Jonah and has not required that degree of care and expense. The journey of the team with Rich has been as personally engaging, although not as dramatic, as the experience with Jonah. The current plan is to formally end treatment at the end of the second year, although informal relations between Rich and the Windhorse community would continue.

A Partial Team: Kathy

An elderly woman approached me following a lecture I had given on the Windhorse program and described the condition of her daughter, Kathy. Now in her forties, Kathy had been suffering since age 18 with a disturbance diagnosed as "chronic paranoid schizophrenia" that had required extensive inpatient care and multiple medications. She had not been able to settle in supervised residential settings and was back with her parents again. Life in the household had deteriorated into intolerable conflict, and her father's heart condition was worsening with the stress. Kathy's parents felt that unless she had a support network by the time they had died, Kathy would succeed with the final in a series of suicide attempts.

A team leader and I met weekly with the family members in their home to mediate conflicts and to establish productive living patterns. The team leader provided case management and one three-hour shift of basic attendance weekly. She was in almost daily phone contact with Kathy and the parents due to frequent crises. We soon moved to my office for weekly team meetings, with Kathy attending on alternate weeks. The team leader continued with the house meetings. I met weekly with the team leader for planning and supervision. Kathy's psychiatrist of 20 years, paid by medical insurance, agreed to our involvement if we did "not provide psychotherapy or meddle with the medications." We agreed to these conditions, but the psychiatrist has since withdrawn them. The cost for the team was a reduced fee of $13 per day to her parents, as they live on a small retirement pension.

After eight months, Kathy moved to an apartment supported by a social service agency with whom the team formed a collaborative relationship. The team expanded to include a student and the director of Kathy's housing agency, who are working as volunteer team therapists with Kathy for their own professional development. Kathy has grown into a capable householder and continues slowly to untangle delusions from accurate perceptions with her increasingly stable attention and discriminating doubts. Upon my leaving

Nova Scotia, the team leader became the principal therapist and a new team member assumed the vacant spot. The team is well-established as a viable learning environment for each member.

The work with Kathy continues to be rugged and understaffed due to insufficient funds. Recently, her allegiance to health suffered a setback with a near-lethal overdose attempt using her prescribed medications. The team stayed close by Kathy and her parents during her awakening from a comatose state. Kathy continues to inspire her team with delightful eccentricity, humor, and sincerity. She may remain with some form of the team for the rest of her life. Her parents regard the Windhorse team as "a breath of fresh air" and are now enjoying their "golden years" together. I remain in contact with them and the team by phone and letter.

THE DISTINCTIVE FEATURES AND IMPLICATIONS

The Windhorse program for recovery is a viable alternative to contemporary care offered in long-term inpatient and residential settings. Each treatment team provides compassionate in-home care for a person enduring psychosis or its after-effects, to facilitate his or her recovery of a dignified and meaningful life. In practice, the Windhorse program works with the imbalances in the biological, psychological, social, and spiritual dimensions of the whole person, as illustrated in the three clinical vignettes.

1. Biological Dimension: The team utilizes a range of physical treatments in addition to psychiatric medications. Medicines are used sparingly, intermittently, and for as long as is necessary without committing to long-term maintenance regimes. Care is taken not to cloud the client's awareness or to excessively blunt the level of arousal, in order to maintain optimal learning ability. This orientation is a source of dialogue with each team's attending psychiatrist. Proper diet and behavior are emphasized, and appropriate physical therapies are considered, such as acupuncture, massage, or movement therapy. A schedule patterns healthy rhythms of daily living. Maintaining a clean and uplifted household is essential.

Care of the body and the environment that promotes wellness is the ground of recovery and the context for the proper use of medication.

2. *Psychological Dimension:* Basic attendance fosters the synchronization of the client's body, mind, and environment. The forms of basic attendance are individual psychotherapy, practical or ordinary therapy, specialized group meetings, and family work, which are all integrated into a single team for each client. Gentle and disciplined friendships between staff and client gradually develop, which bridge the alienation that is usually the result of the psychotic disturbance, of cultural stigma, and of rigid professional distance. The client is able to recover hidden psychological resources of intelligence and courage within him or herself that are essential in overcoming the fears and self-aggression that shadow any psychotic episode.

3. *Social Dimension:* Treatment and recovery are carried out under ordinary life conditions in individual households in the community. Grouping disturbed persons together in one place may risk everyone's health and reinforce stigma. The team attends to the boundary between the client and the practical tasks of living and working in the larger social world. The client is accompanied by the same therapists through all stages of recovery, eliminating the stressful transitions that clients experience when they are abruptly admitted to and discharged from discrete programs in sequential levels of care. The "revolving door" problem, such as going in and out of the hospital, is lessened, since the intensity and cost of the team adapt to the client's changing condition. Client and family become active collaborators in the team as a micro-healing community, and the benefits of involvement are shared among everyone. This intimacy of mutual caring fosters bonds of human kinship similar to an extended family or clan.

4. *Spiritual Dimension:* The Windhorse community does not promote any particular religious doctrine. It does cultivate a field of dialogue in which the broad range of staff and client experiences can be safely expressed and responded to. Clients repeatedly ask their caregivers to listen, without judgment or denigration, to their

cherished spiritual concerns, such as their relationship to good and evil or to the "divine." Compelling glimpses of ultimate meaning always occur in some stage of psychotic disturbance. Similarly, staff may ask to explore the meaning of true compassion or the relationship of their personal spiritual practice to clinical work. Many Windhorse staff and clients have found contemplative disciplines to enhance self-knowing and to widen awareness beyond private concerns. Members of the Windhorse community are attempting to live productively and creatively together, enlivened by a spirit of learning. To engage in healing is traditionally a sacred art that attends simultaneously to the ill person and to other community members, and reharmonizes the community with the surrounding environment. This perspective joins social ecology and spirituality together in a time-honored way (Knudtson and Suzuki, 1992).

The future of mental health care is increasingly driven by the consumers/survivors of conventional treatments, which are influenced by the medical model of psychosis as a brain disease best treated with brain medicine. Consumers insist on being offered humane, whole-person treatment alternatives. The medical model was once the promising alternative to outdated treatments, and it is reasonable to assume, since all models have historically proved to be provisional, that future paradigm shifts are inevitable. There are already signs of a transformation of Western medicine "from a narrow biomedical model to a biopsychosocial one" (Barasch, 1992, p. 36). American mental health care is now in a crisis of rising costs, inaccessibility to shrinking community services, and increasing reliance on brief crisis hospitalizations and psychiatric medications (Dumont, 1992). In addition, the political and economic alliances between the psychopharmaceutical industry and psychiatry are an increasing source of embarrassment to the profession, and the obvious conflicts of interest left unresolved will intensify the crisis. One can certainly rely on the occurrence of alternatives to any established system in a crisis of transition. However, as with psychosis, whether such outcomes are healing or destructive depends significantly on our actions now.

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