
Into the Mythos

I thought the whole world was based on Greek mythology and I actually believed all this, and I was like, “Okay, that actually makes sense.” Like I had memories from my childhood just coming up and I would connect my crazy thoughts to those. I was like, “Okay, that’s why I had that moment in time with my family because we were actually Mary and Jesus or something like that,” so I was just thinking, like, a lot of crazy stuff and it was, like, just completely disattached [sic] from reality.

—JAMES, STATE HOSPITAL, WEEK 3

As Amy walked along the narrow shoulder, the bridge vibrated. Cars and trucks zoomed below.

When I fly, they will know I am a superhero.

“Just try it!” the voices in her head were shouting. “You can fly!”

“It just popped into my head,” Amy told me later. “I should jump off the bridge to see if it’s real.” Amy stood there, arms limp, staring down at the blur of traffic.

Can I fly?

Amy had shoulder-length copper hair and moss-green eyes. She self-identified as white. Her brother and sister, Robert and Addison, raised her after their parents died. Instead of finishing high school, she dropped out to take care of Robert’s small children. She then worked hard in dead-end jobs, and when she ended up unemployed due to circumstances beyond her control, she wanted a fresh start. So she moved in with Addison’s family in a different city until she saved up enough for her own place and found a new job.

However, the new job did not work out. During our early interviews, Amy shared that her new coworkers had been “zapping her in the chest,” causing her chest pains. This had troubled her.

“Why would my coworkers want to harm me, right?” she asked me.

Unemployed again, Amy became very depressed. She had no car, no apartment, no friends, and no romantic prospects despite her so-called fresh start. After watching Amy lie around on the couch all day, Addison suggested Amy help watch

her children. She had helped Robert, after all, and his kids loved her. Addison could use the savings on the cost of childcare to help cover Amy's room and board.

This arrangement worked for a little while. Amy was attentive and fun with the children, taking them to parks, teaching them about colors and numbers, and making sure they took their naps. However, things started to seem a little off. Amy sometimes said odd things about "brain zaps." When she had a panic attack after not being able to get a refill at the pharmacy, Addison suspected that Amy was misusing her ADHD medication.

Then, one evening, Amy barged into the children's room when Addison and her husband were reading them bedtime stories. She started screaming at Addison and her husband, demanding that they get out of the children's beds, accusing them of molesting their children. It was hard to calm Amy down.

Over the next few weeks, Addison and her husband tried to reassure Amy that they were not abusing the children during bedtime story reading, but Amy became increasingly agitated. She called the children's school nurse to demand that she check the children for sexual abuse. Child Protective Services opened an investigation. It was a nightmare.

Addison and her husband decided that Amy needed to move out. No one could afford a hotel, so they called around until they found a nice women's shelter with an open bed.

When they told Amy that they wanted her to stay at the shelter and look for a new place to live, she became violent. Amy later explained that she thought that if she left, her sister would poison her niece and nephew. She threw their plates and glasses against the wall, taking care to break them all so that the poison could not be administered.

"I didn't mean to be harmful to her or anything," Amy told me sheepishly; "it just happened that way."

Amy's siblings—people who loved her, who felt like her parents in the absence of their own, who wanted the best for her—now found her to be incomprehensible. They could imagine neither where Amy was coming from nor what motivated her to hurt them this way. Amy and her family had no shared sense of reality. Their common ground of familial love and trust—the taken-for-granted mutual moral understandings—were gone. Their shared sense that they were "good" people having a "good" relationship was breaking down. Sadly, this went both ways; Amy also thought her siblings were "bad" people.

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Feminist philosopher Margaret Urban Walker writes that to live responsible and moral lives (whatever that means to us in our own social contexts), we must preserve "moral understandings" with people we want to be in relationships with, and to do so, a kind of story needs to be sustained among everyone. "We need to keep

on keeping straight who we are,” Walker writes, “and who we have given others to understand we are, in moral terms. We also need to sustain or refurbish our understanding of moral terms themselves, of what it means to talk about kindness, respect, friendship, or obligation.”¹ These shared cultural notions of kindness and respect are the glue that binds moral agents together in relationships that matter to them.

In this instance, Amy’s story about who she was in relation to others was not shaping up. She was losing her autobiographical power, or her reliability as a storyteller worth listening to. Everyone in Amy’s family was caught up in a damaging vortex of toxic interactions, and their responsibilities to one another were collapsing. Amy thought her family should be taking care of her—and their other children. Amy’s family thought she should be responsible for contributing to the family’s well-being, not undermining it. Amy’s ability to be responsive and responsible in ways that were meaningful to her loved ones was gone. Yet in Amy’s mind she was being very responsible. In fact, she thought she was a superhero, sent to save her niece and nephew from sexual abuse.

Maybe if I show them I can fly, they will believe me, she would later consider, while standing on the bridge. What if I can fly?

When the symptoms of psychosis emerge, it becomes clear to others that a person is experiencing something that is wildly divergent from what most of the people around them perceive as reality. Some people call this nonconsensus reality. People perceive or interpret *consensus reality* together: it’s something on which they can mutually agree. Nonconsensus reality is not shared with others.

In anthropologist Sue Estroff’s seminal work on Americans with psychiatric disabilities, *Making It Crazy*, she wrote, “Most of what we know to be real is what we share with others.”² In this case, Amy was outside that shared reality. As she lost consensus with others, Amy began experiencing a “moral breakdown,” or the point at which her sense of reality was so incommensurable with others’ that her own sister and brother could no longer understand her.³ Her moral agency was at an all-time low. This was a breaking point.

The manifestation of psychosis is an unmooring enacted in relationship with others. Medical sociologist Essya Nabbali wrote, “With mad people, very specific behaviors transgress cultural mores and it is these behavioral disruptions which become their supposed impairment.”⁴ In other words, madness is a person’s inability at times to share in consensus reality and behave according to the norms, expectations, and responsibilities assigned to them.

However, it’s not just the perceptions of a nonconsensus reality that can make things so challenging. In some ways, it is the attempt to *make sense* of nonconsensus realities that can seem so odd. This is one of the terrifying loops of psychosis. Just when Amy thought she was saving the world, she was damaging that world by her actions. Her right to tell her story, to feel the glow of self-respect from the confirmation and support of Addison and Robert and the children, and the people

opportunities that having these loving relationships created for a place to feel safe and loved, all were all diminished because she was trying to do what she perceived to be her responsibility and no one else agreed.

How do people who love and care about one another bridge the gap that non-consensus reality creates? To begin, it is important to understand as much as we can about where a person with psychosis is coming from, why they are acting as they are, and what their nonconsensus reality is. It is hard to guide someone back home when no one is using the same map.

From a clinical perspective, most psychiatrists would define Amy's anomalous sensory experiences as symptoms of an emerging psychotic disorder, which is exactly what happened when Amy went to Shady Elms. This is how she qualified for my study. Most of the young people I met were diagnosed initially with "psychosis not otherwise specified" (psychosis NOS), which meant that they had some signs of a psychotic disorder that had seriously disrupted activities in their everyday lives, such as their success in schooling and employment, but not enough time had elapsed to evaluate them thoroughly. A diagnosis of a psychotic disorder takes at least a month; Amy was diagnosed after a short stay in an emergency setting.

The diagnosis of psychosis NOS signaled to other clinicians that Amy was at least experiencing some positive symptoms of psychosis, or possibly both positive and negative symptoms. People are not usually diagnosed based on negative symptoms alone, though. Positive symptoms are conceived as something "extra" added to reality, like hearing voices that no one else hears or seeing things no one else can see. Negative symptoms are understood as signals that a person is lacking something, such as motivation or an ability to experience pleasure or to show emotions.

Many young people use substances recreationally, so the research team sometimes had to wait for substances to clear their systems before their clinician was willing to assign them a diagnosis of psychosis NOS instead of "substance-induced psychosis." Occasionally a young person was brought in a few times for what seemed to be substance-induced psychosis before they received the more formal diagnosis of psychosis NOS. Substance misuse sometimes leads to psychotic reactions, but clinicians thought that a person was unlikely to have a psychotic reaction multiple times in a row if there was not some underlying psychiatric disorder.

We also know a little about what can cause psychosis. Substances are not necessarily a direct cause. As mentioned in chapter 1, cannabis use may elevate the risk of developing psychosis in vulnerable people or lead to development of psychosis at a younger age than the person may have otherwise, but it is only one small piece of the architecture of risk.⁵ Many other social factors also elevate risk, and most of them are related to stress. Adverse life events and cumulative social disadvantage raise a person's stress level and their risk of developing psychosis—a risk that seems to rise exponentially as those factors accumulate.⁶

Some people live with psychosis symptoms and do not seek psychiatric care: they are known as people with nonclinical psychosis or psychotic-like experiences. It could be that their lives are less stressful, or that they have better ways of managing stress or their symptoms than those who struggle and seek—or are forced into—clinical support. People who do not struggle with their symptoms also report having more positive experiences of voices and visions such as hearing Gods or angels—as opposed to negative voices like demons—and experience them less frequently.⁷

Others do struggle—and suffer.⁸ Amy had persistent symptoms that severely disrupted her everyday life. Her zaps and voices made it hard for her to work, and her ideas about the world—that her sister and brother-in-law molested their children—completely isolated her from her family. She did not have any romantic partners or friends and was not employed or in school.

To better understand Amy's experiences, we can turn to several sources beyond the clinical literature. One includes the narratives of those who self-identify as persons with lived experience of psychosis. There are many: psychologist Gail Hornstein maintains a list of more than one thousand such narratives, dating back to the fifteenth century.⁹ Another source is research led by people with lived experiences of psychosis, sometimes called service user research, survivor-led research, or user-survivor research.¹⁰ People with lived experiences of psychosis bring their own experience to the table as they design studies and collect and analyze data in interdisciplinary ways.¹¹ Their perspectives can usefully complement and contradict clinical perspectives.¹²

Another resource consists of the results of studies like mine that involve researchers who have presumably not had experiences of psychosis. These studies ask persons who have had psychosis about their anomalous experiences in an intentionally respectful and empowering way. For my interlocutors, psychosis seemed to wash over them in a series of waves, at different rates and speeds, sometimes pushing or pulling in all kinds of directions—sometimes in a peaceful, lulling drift, but often moving them further from the shore of consensus reality. They felt as if they were being coaxed toward the breaking point. When you're playing in the waves, a breaking point occurs when you are knocked down, bowled over, and smothered by sandy water. In the case of a psychotic break, this is the point where you completely lose touch with reality. I think of the breaking point in psychosis as an inundation of perception when an overwhelming amount of sensory input becomes unmanageable. Once you are at the breaking point, if the waves are large, it can be hard to fight your way back to shore.

To demonstrate to my students how it might feel to be caught in the breaking point, I start by asking them what happens when they experience stress. For example, how do they feel when they must give a presentation to the class? We then discuss the inevitable answers—sweaty palms, accelerated heartbeat, dry mouth, a churning belly. Next, I ask: *What if your reaction to stress was to hear sounds or*

voices that other people cannot hear or see things other people cannot see? Looks of concern all around.

After this, I have them listen to an audio track called the Hearing Voices Simulation, developed by clinical psychologist Patricia Deegan,¹³ who herself hears distressing voices and has been diagnosed with schizophrenia. The audio begins gradually with random noises—scratching, bells, and voices speaking random words—“jerk . . . alert.” It continues with “You smell” or “You’re a piece of shit.”

Next, we watch a YouTube clip of the television journalist Anderson Cooper listening to the same simulation.¹⁴ He puts on headphones, plays the audio track (which lasts ninety minutes), and tries to do simple tasks like crossing the street and ordering coffee. He is quite distressed. Anderson also takes a battery of cognitive tests before listening to the simulation and then takes them again while listening to the simulation. His scores drop significantly when Deegan’s soundtrack is playing.

This exercise offers my students a sense of how distracting and stressful psychotic symptoms can be. They are almost impossible to ignore. Some go home and try to do work or check their email while playing the voice simulation through their earbuds to see how it goes. I tried out this exercise personally in graduate school, though in my case I was listening to a tape on a Walkman. I found the experience disturbing. It was hard to order a coffee. Hard to cross the street. Hard to think my own thoughts. Impossible to have a coherent conversation. I have never met anyone who enjoyed the simulation.

Most students tell me that, after this experience, they became more empathic toward people who hear distressing voices. Some tell me they will never forget it. Others worry that this might happen to them. I cannot promise them that it will not.

How difficult would it be, I ask them, if this happened often and the voices were interactive and personalized—saying things that matched one’s life in some way? Would they start to believe the voices or be compelled to act on their suggestions?

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Markus, a 21-year-old Black man, was clinically stable when the treatment team recommended him to my study, but it seemed he was still struggling with the waves of psychosis. Despite his confusion, Markus tried to help those around him see him as a good person, but his symptoms seemed to make interpersonal connection challenging.

INTERVIEWER: Tell me about your life’s goals. What are your goals in the future?

MARKUS: I want to be the best that I can be.

INTERVIEWER: That’s great.

MARKUS: I want to prove that I’m one of the best to do it. That’s what I want to prove. I won’t stop until I prove it. I won’t stop till I prove—

[Long silence.]

INTERVIEWER: How are you going to prove it? What are you going to do?

MARKUS: Keep working with the people I need to work with so that I can have my business at all times. Stay focused.

[Another long pause. Too long for the interviewer.]

INTERVIEWER: How are you doing, Markus?

MARKUS: I'm doing good.

INTERVIEWER: Yeah?

MARKUS: Mm-hmm. *[Affirmative.]*

INTERVIEWER: You seem like you're really distracted.

MARKUS: Little bit. Little bit.

INTERVIEWER: You are distracted, right?

MARKUS: Yup.

INTERVIEWER: Are you distracted by somebody outside [the glassed-in cube]?

MARKUS: Mm-hmm. *[Affirmative.]*

INTERVIEWER: Who is it?

MARKUS: Somebody who guides me.

INTERVIEWER: Somebody who—?

MARKUS: Somebody who guides me.

INTERVIEWER: Guides you? Yeah?

MARKUS: Yeah.

Markus tried to express himself in terms the interviewer could understand. He explained that he knew what he was supposed to do as a young adult—be the best, work cooperatively to have his business, stay focused. Yet Markus could barely pay attention to the interview because he was experiencing a hallucination that was both auditory and visual. The seasoned interviewer could tell it was not a good time and arranged to come back later. Markus's "guide" in the nonconsensus reality was compelling—so compelling that he brought it up to explain his confusion.

Psychologist Eleanor Longden described in her TED Talk how the voices drew her in slowly.¹⁵ They started with seemingly benign, third-person observations about her, such as "She is opening the door." The voices were friendly and didn't worry her, until she told a friend, who was horrified, and Eleanor started to believe that something was seriously wrong with her. When she sought help, her general practitioner referred her to a psychiatrist who, in her perception, viewed everything she said "through a lens of latent insanity" and hospitalized her involuntarily. As Eleanor's fear of the voices grew, the voices turned into multiple, negative, persecutory voices that "were both my persecutors and my only perceived companions."

User- or survivor-led research, conducted by persons with lived experience of psychosis, claims that when people focus on listening to their voices, those

voices often take on even more voice-like qualities, which can be overwhelming.¹⁶ According to our consultant, psychologist Nev Jones, whose work is deeply informed by direct experience of mental health services and engagement with the user-survivor movement,¹⁷ if someone experiencing psychosis thought that people at a cocktail party were talking about them (when they were not), the more they tried to listen, the more they would hear, and what they heard would become more disturbing and more specific. This psychosis-confirming thought loop is disorienting and dangerous. The Hearing Voices Simulation demonstrates how cognitively disorienting a soundtrack of random, nonpersonalized voices can be. What does one do when the voices become personal and interactive?

In one of his interviews with me, James, the young man introduced in chapter 1, described how paying attention to the voices made them seem more real. He told me that he heard two voices, a reality voice and an alternative reality voice. Both talked in James's voice (it sounded like him to him), but the alternative reality one was "the crazy one, telling me I'm Jesus." In contrast, the "reality voice" was "calming" and said things like, "No, you're just normal. You're still not broken, yet. You're not slipping away too much." He also called the reality voice "just pretty much the voice of silence," whereas the alternative reality voice was "just thoughts always just running through my head. Constant thoughts."

"Just like a stream of consciousness?" I asked.

"Yeah," he responded, "like if you're reading a book, you're hearing that voice?"

"Sure," I nodded.

"Like your reading voice, so if you're thinking about something seriously, like consciously, you'll hear a voice, right?"

"Right," I said.

"But, for you, it's not like just like a voice that's just involuntarily going and going . . . So that's the worst part is that voice sounds believable, so we start believing it and since you're in that psychosis—you're already psychotic—so you just believe it anyways without a doubt because it's your mind, so you're like—you just believe your own mind, you know?"

"Right, well, yeah—who do you trust if not your own self?"

"Yeah, right! *It's your own mind.*"

James looked pleased that I understood, but I didn't really. I could never understand what it feels like to have an audible, negative voice persistently presenting me with a compelling alternative explanation for reality that no one else shared beyond the voice and me.

But voices and visions are only part of some people's experiences of psychosis. Some people had sensory experiences like being "zapped"—an experience Amy mentioned, as well. Jones and colleagues have written that participants in one of their studies of the phenomenology of early psychotic symptoms discussed their symptoms in "richly embodied ways."¹⁸ These included sensations of anxiety that were not "in the mind," such as a feeling that one was being watched, followed, or

“invaded.” The entire body was involved in this “knowing”—not just the brain. One’s entire neural network could be engaged.

Like Markus, Corinna also found it hard to attend to consensus reality when she experienced symptoms, and even her description was full of contradictions, which she recognized as she tried to describe them retrospectively:

It feels like your brain is kind of like a puddle. Like it doesn’t have any shape to it. It’s an amoeba that’s just floating around. This doesn’t make sense [. . .] It just feels like there’s too much going on, but not in the same sense where if you’re in a room and there’s a lot of noise. It’s not the same. It’s like a sensory thing, where you’re sensing too much, not too much noise, but there’s just too much of everything going on [. . . And] you’re just so focused on what you’re feeling, that you can’t really focus on what’s actually going on. And you’re not feeling anything. I mean, there is anxiety with it, but it’s not focused on anxiety, where if you had a panic attack or if you had anxiety, you’d know, like, “Okay, this is all about anxiety.” This one, you can tell the anxiety is coming from it and also from the fear of, like, “Okay, what’s about to happen? I don’t know what’s happening.” So it’s just spacey. It feels spacey and it feels like you’re detaching, like you’re being pulled away from what is really reality.

Corinna’s retrospective description of her experiences makes a few things clear—the symptoms were compelling, they were overwhelming, and she felt that they pulled her away from “what is really reality.” It became “too much.”

Anthropologist Luke Kernan beautifully described his own experience of psychosis in terms of an intense, holistic way of knowing and being, calling it the “seduction of psychosis”:

The way it peels one’s being to rawness, induces an electric excitement anguished by and of its overabundant sensory connectivity—the capacity itself starts with a subtle motion. The vibrancy of the world comes into attunement, onsets with a hypersensitivity that commissions the sensuous. *The way a flush of colors flock before the eyes—so blue its waters become palpable triples of an Australian rainfall, so green its glow reminds you of the emerald irises of your first kiss—those moments with all their affective rage sculpting the body.* These currents of non-normative consciousness flow inward, spark outward—to alter the grammar of what each sensory unit collects and, thereby, to render reality as otherwise.¹⁹

Kernan’s sensory flooding was so intense as to become consuming, compelling, even appealing. And it made participation in consensus reality extremely challenging.

As mentioned earlier, Nev Jones and her colleagues and Eleanor Longden both argued that the more one pays attention to experiences of psychosis, the more compelling they become.²⁰ Psychosis thus confirms itself in a looping effect. The messages start off vague and amorphous—“you’re being zapped”—and then gradually entice you a bit further in: Are your coworkers zapping you?

People who have experienced this looping tell me that the psychosis seems to have an agency of its own. It speaks to them and over time that speech becomes



FIGURE 2. “Identity” by Lauren Ann Villarreal. In an email, the artist wrote to the author: “It’s about how I fully lost my grip on my reality, myself. I felt like I was desperately trying to hold on to fragments of myself and trying to piece them together hoping I would look like myself again. This piece is also about trying to keep my eyes focused and open, because I felt like they were the only part of me that hadn’t fully unraveled yet.” *Reproduced with permission of the artist.*

more personalized. The loop, then, seems to follow this logic: the more you pay attention to your psychotic experiences, the more personalized they become; or the more you pay attention to psychosis, the more attention psychosis pays to you, almost like interacting with an artificial intelligence focused on strengthening your belief in an alternate, nonconsensus reality that is also always already your own.

It is difficult to know just how much control people with psychosis have over this cycle—whether, in some ways, they actively and deliberately engage in or perpetuate the loop. While many people think that psychotic symptoms are not within a person’s control, our interlocutors felt that sometimes they were. And, according to the literature, this occasional control only made them feel worse—as

if maybe they were more responsible for what had happened to them than others thought. Nev Jones and colleagues argue that this engagement can later lead people to feel shame as they question whether they had agentively, actively “pushed themselves over the edge.”²¹

Jones and colleagues’ interview participants—young people who had experienced early psychosis—described having some agentival control over their symptoms. Sometimes, they claimed, they could ignore them and actively push them away or choose to engage with them further. Corrina mentioned something similar in her interviews.

“You can tell when it’s coming,” she said. “And sometimes you can fight it and sometimes you can’t. Like sometimes I’ve been able to be like, ‘Just ignore it. Focus on what you’re doing and just don’t think about it and it’ll just go away on its own.’”

Overwhelmed by experiences that had no acceptable place in our culture but that looped around to confirm themselves as real when attended to, the young people we engaged tried to keep pace with these very real experiences that were not part of others’ consensus realities. At the same time, they struggled to know, as Corinna and James asked, What is really reality?

When a person gets lost in this process of hyperreflexivity, they typically disengage from the shared common sense about what we can assume and how we can act that is typically the “taken-for-granted foundation of organized action and experience.”²² We can certainly see this happening for Markus, James, Amy, and Corrina. As their senses became overwhelmed, they had trouble connecting their very real psychotic experiences to others’ shared everyday consensus realities. In addition, the more they paid attention to nonconsensus realities, the stronger the presence of those alternatives became. The more they looped, the deeper the groove became: the harder it was to find their way out of its rut. They were disengaging with the world and engaging more with their psychosis. As one friend who has experienced psychosis told me, “It was interacting with me, and I knew it was coming from me, but it was not me.”

Social isolation only magnifies the experience. A clinical psychologist with lived experience of psychosis, Rufus May, reflected in a recent piece that “a magical child emerged from my psyche to protect me from the loss of roles and relationships.”²³

Sometimes, as with Markus when he was following something with his eyes beyond the glass, people can observe a person experiencing psychosis interacting with their nonconsensus reality—waving away spirits, punching a demon, trying to block incoming sonic assaults, whispering to someone no one else can see. These visible signals of psychosis can make other people feel uncomfortable. It is hard to watch someone struggle against something you cannot see. It is scary to see that someone is experiencing a perceptual field that you cannot access and that is so potent for them that they are responding to it physically. It is not always clear what this means for your relationship with them or even your personal safety.

Legal scholar Elyn Saks described her own strange bodily movements: “As I grew steadily more isolated, I began to mutter and gesticulate to myself, something

I had never done on my worst days. [. . .] When I heard the sounds I was making, I felt neither disturbed nor surprised; for some reason, it helped me feel calmer. It seemed to provide an arm's length distance between me and the people who were walking past me. Oddly, it was soothing, much like clutching a well-worn blanket."²⁴ Even so, making unusual movements with one's body that break cultural norms for adults contributes to social isolation.

As Corrina's psychosis strengthened its relationship with her, her social relationships with other people wilted. Or maybe it was vice versa: as others took a step back from her and her unusual behaviors, the psychosis replaced them. Corrina's social life in consensus reality was hard to maintain. She explained:

It makes you really stressed, because at the same time, since you can't control it, it's like you don't want to be suddenly out of the conversation or be gone, but it's like you literally can't pull yourself out of it. And then you can't function. I wouldn't be able to sit here and talk to you guys. I would just kind of be like this, or listening, or just leaning back and trying to figure out what's going on, because I know that that's what happens. Like I usually withdraw. I can't be social. It's not that I don't want to. It's that—you can't.

This withdrawal also happened to James and Amy. Their symptoms isolated them. They became confused. The hallucinations and delusions reinforced one another. The more compelling the psychosis became, the stronger its pull became and the harder it was to escape. They actively withdrew from social life, trying to sort things out on their own.

Psychiatrist and anthropologist Ellen Corin and psychiatrist Gilles Lauzon characterized this behavior as "positive withdrawal," which they identified as a strategy their patients with long-term schizophrenia used to feel better.²⁵ For their patients, positive withdrawal created a buffer zone between their own inner, lived world and the world of others—a boundary that often blurred when they tried to engage fully and became overwhelmed with sensory input. Positive withdrawal helped them cope with and process sensory input at a distance, giving them time to form clearer ideas about what was real and not real, self and other, and thereby strengthen their sense of consensus reality before they tried to interact with anyone. Corin and Lauzon found their patients kept social interactions very brief and casual so as to enjoy human interaction but avoid rejection.

Corinna was quite withdrawn when she changed from Karina back to Corinna, having spent several weeks in her mother's home without visiting anyone. She made it clear that it was difficult for her to be alone, especially as a young person who was supposed to be finding her romantic partner, occupation, and urban tribe. Instead, she needed to stay away from people to avoid seeming strange, though her need to withdraw also made her stand out, resulting in further negative experiences and rejection.

"And then you feel awkward," she said, "because obviously you're the only person who really knows what's going on with you and everybody else is just going

on with whatever they're doing. And then a few notice [. . .] you stand out 'cause something's wrong with you. [. . .] It feels like you've taken a drug, and you didn't, but you can't control it anymore [. . .] And then you get scared, 'cause you can't control it and you're just like, "This sucks."

Corinna looked at me and gestured to all the things—my research assistant and me, my tape recorder, her mother, and her mother's dim living room, where she had spent the past several months afraid to leave the house.

"This sucks."

We all started laughing, laughing in that way that feels a little hysterical, a little like survival. A quote from Emily Saliers of the Indigo Girls crossed my mind: "You have to laugh at yourself because you'd cry your eyes out if you didn't."²⁶ I felt like crying, too.

Corrina continued: "But, yeah, you don't know how long it's gonna last; you can't necessarily control your body. You just can't function. Like you can't do anything really. All you can do is just sit there and try not to freak out."

She laughed again, but the rest of us did not.

"You have to laugh because it just sucks," she said. "That's why you have to laugh."

Young people like Corrina and James cannot afford to withdraw positively or otherwise. They are at a time in their lives when they are under pressure to make a successful transition to adulthood, when it is more important than ever for them to engage socially. They need to find their place, their people, their purpose, a sense of belonging. And they felt that they really were not supposed to be at home with their families. As Corrina said, being at home sucked.

So even as they experienced overwhelming sensory inputs and became more ashamed and isolated, they tried to make sense of their experiences alone so that they could reengage with the world. One strategy they used was to mobilize culturally available stories, or mythos, to make sense of their symptoms. As Rufus May wrote of his magical child that protected his psyche from the loss of roles and relationships: "To be immersed in a world of espionage and magical connections made me feel valued and gave me a sense of purpose."²⁷ Amy was a superhero. James was most often a celebrity but sometimes also Jesus. Markus had a guide. Corrina was an angel.

David was a prophet.

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David, a tall, well-dressed African American youth with a bright smile and hipster glasses, strolled cheerfully around the airport terminal, wheeling his carry-on bag. He could not wait to see his mom. It had been a long time, and he wanted to tell her the good news: his head was booming with the voice of God.

"I am a prophet, and God loves you!" he told the cashier at a snack kiosk.

“God wants me to tell you that you are sinners and you need to repent!” he shouted into the air as he made a stop in the bathroom.

“God said to tell you that you will die soon,” he told the young woman behind him on the boarding ramp.

She did not look up from her phone. David felt hurt.

“Did you hear me?” He asked her again.

She continued to ignore him.

“Hey!” he said. “You need to repent before you die! Why won’t you listen to me?”

People around him were not sure what to do.

“God is telling me that you are all sinners!” he shouted in the middle of the jetway. “You are all going to burn in Hell for your sins! Repent!”

David’s urgent call to evangelize was overwhelming him. Noticing that people looked uncomfortable, he attempted to calm himself. He wanted to get home to his mother, and to do that, he needed to be on this plane. He fiddled with his bag and tapped his feet, but he was fighting a great battle.

“Stop it! Stop it!”

Did I say that out loud?

The flight attendant looked at his ticket. She took his bag. “I am going to need to gate check that for you,” she said and then reached for the phone.

David rolled his eyes and proceeded down the aisle. He tucked into his seat and closed his eyes to rest while God prattled on. He did not notice that no one else was boarding. He did not even notice the men approaching him.

“Are you okay, young man?” one of them asked. He showed him a badge.

David felt so irritated. Why were the police always hassling him?

“Oh, right, so why don’t you just check my bag for a bomb already?” David shouted. “America is the land of the free. And I am free,” he stood up, his anger overwhelming him, “to SPEAK in public!”

The officers acted so quickly, he was not sure what happened next, but he quickly found himself in the airport security office, handcuffed and waiting for his dad to come pick him up. Security had confiscated his suitcase and his phone.

When David’s father arrived a few hours later, airport security released him. David did not have bombs or anything threatening in his bag. He seemed exhausted and disoriented but had been quiet after they took him off the plane.

David’s father told security that he was sorry. He explained that David was having some mental problems, and the family was just trying to get him back to his mother in another state for a visit. They had not realized he was too unstable to fly.

On the way home, David tried to explain to his father what happened; they argued. David knew he was God’s prophet. He refused to back down. His father needed to understand how important it was to repent.

His father was heartbroken. What had happened to his son? How could David believe that God had told him to behave in a way that would make him terribly

unsafe, that drew the attention of the police, that got him arrested at the airport? David became so upset at his father's rejection of his prophetic skills that he tried to jump out of the car. His father knew something had to be done. He had to keep his son safe.

When he stopped for gas, David's father called 911 while David went to the bathroom. They told him to stay put. He pretended he could not find his wallet to pay for the gas until the police arrived to collect David from the gas station parking lot. A few days later, my team met up at Shady Elms, and he shared more about his experiences.

David described himself as "a military brat with divorced parents who suffers from low self-esteem." When he was 10 years old and his parents divorced, David stayed with his father, but it was hard not having his mother there. To cope, he started smoking cannabis when he was about 13, served some time in juvenile detention, and then tried methamphetamines around age 15.

"I simply got into weed by being a cool person," he said. "But I didn't know I was cool already."

By the time a member of my team interviewed David, he had been in and out of several court-ordered substance abuse rehabilitation programs. He had been homeless. He had been to college. A new church community he had recently joined had helped David get sober for a few months.

His father, David said, did not understand why he was a "bad kid," but David knew it was his father's fault. "The Bible says, 'A bad seed produces a bad seed. A dying tree is not going to produce good fruit,'" David said. "They [his parents] don't understand because they don't hear the same voice I hear."

David had been hearing God speak to him for about a year. "It's like having a positive conscience. I don't think about stealing, lying. [. . .] I know to listen to the voice because the Bible says, 'We are servants unto God before anything else.'"

David knew that he had been a liar and a thief and an addict because he had a rough childhood, but when he found God he felt transformed.

"I am a very mature young man," he thought.

He felt bad for everyone else because they were "mixed up because seeing something spiritually doesn't mean that somebody's crazy all the time."

David had no plans to take medication. He thought that taking medications would limit his ability to see Satan:

I think it gives room for Satan to come because you cannot see him. I can now, but not a scary figure somewhere. I can see people's eyes change and stuff like that. I don't like talking about it because I know that people who do not believe what I can see because they can't see because the first thing they say is something like, "He needs to get his brain checked and be healthy." If they don't believe, they just don't believe. That's why I don't like to talk about it with people. Even my dad, who is a Christian, does not believe me, and it hurts. If I was a preacher or a prophet or if I was walking on water like Jesus, then everybody would be like, "Okay!" Some people would be like, "Oh, he's doing magic or something."

To avoid staying in the hospital again, David said, he would handle his dad differently, maybe not try to tell so many strangers about his gift of prophesy, and “maybe then [my dad] will see that there’s something special in me.”

David felt strongly that he was on a mission. “I’m just a man on the road destined to become a preacher, which is harder living spiritually.” He sighed. “My family just doesn’t understand the spiritual change that I’m going through. That’s it.”

David very much wanted to impress the judge who was going to rule on whether he could leave the hospital, which meant he had to prove he was no longer a danger to himself or others. He wanted to be released because, “that way, they won’t keep moving me towards mental illness because that’s depressing enough.”

When asked if he had anything to add, David said he wished he could walk on water. “If I was to do that, the whole spiritual thing would go crazy. People would want to come see me.” Even so, he added, “I think I can go far. There are famous people across the world who do things for God. They can heal people.” David wanted very much to be a healer.

. . .

Many people with psychosis talk about supernatural content, and “hyperreligiosity” is on the list of “positive” symptoms of psychosis. One study found that 39 percent of people with a psychotic disorder discussed spiritual concerns with their clinicians.²⁸ I suspect the percentage of people experiencing spiritual concerns is even higher, since many may have already learned not to discuss their angels and demons with their clinicians or did not feel invited to do so in the first place. As a philosopher with lived experience of psychosis, Wouter Kusters writes that madness is “the socially awkward expression of a desire for infinity in a world that defines itself as finite. . . . The mad world abounds with Jesus characters, Mary visitations, revelations, prophecies, Gods and demons.”²⁹ People need their psychotic experiences—which are real to them—to make sense, to matter.

Kusters, who has experienced two psychotic episodes in the past twenty years, argues that mad experiences are often philosophically and medically ascribed to the “mentally defective” and so treated as “out of bounds as a nadir of meaninglessness.” Kusters thinks that nothing could be further from the truth. Instead, he argues, mad people have been “seized by themes of vital importance” that also “animate the ideas of philosophers, mystics, poets, shamans, absurdists, magical realists, and many others.”³⁰

This struck me as true for the young people I engaged, as well. Their thoughts were animated by a sense of great importance for themselves and others. Some had destroyed their lives as they knew them based on that conviction. Sascha DuBrul, a person with lived experience of psychosis, recalled his reaction when he could not make sense of his own experiences of psychosis: “I started reading too much meaning into everything. . . . Whatever was going on, it was obvious I was the only one who could see it because no one knew what the hell I was talking about!”³¹

This effort to make sense of nonconsensual reality was confusing, exhausting, and self-defeating. Young people lost moral agency by trying to tell other people about their experiences. Then, they attempted to replenish their moral agency by trying to take on a role that others might see as significant, such as a superhero, angel, prophet, or Jesus. If others did not agree, young people typically tried harder to convince others that their spiritual explanations were real, which only diminished their moral agency.

In their article on experiences of people with psychosis whose interviews highlighted spiritual content, Nev Jones, Timothy Kelly, and Mona Shattell explored how individuals used culture and at times religion to describe, interpret, and make matter the “raw” psychotic alterations of perception and cognition.³² They asked people to describe what had happened to them since they had begun experiencing unusual mental events. One of their interlocutors, Levi, a secular Jew, told them that he had made sense of his psychotic experiences through Christian discourses. When he posted his experiences on Christian social media and websites, he received validation from other Christians using those sites. Thus, Levi was able to mobilize Christian dogma to successfully translate his otherwise inexplicable—and often pathologized—experiences into events that were instead “consistent with what’s been going on in Christianity for millennia,” even though, as a secular Jew, he did not believe those events were true.³³ This “double bookkeeping” empowered him to make sense of his unusual mental events in an online community with others where the stakes were perhaps lower than among his everyday friends and family.³⁴

Anthropologist Tanya Luhmann argues that religion and spirituality constitute “cultural invitations” that can open the door to alternative interpretations of anomalous experiences.³⁵ A person can choose to accept or ignore these invitations. Using Jones, Kelly, and Shattell’s example, we could say that Levi had tapped into Christian America’s cultural invitation to engage in a realm of happenings that is neither purely imaginary (there is at least a historical Jesus) nor part of everyday consensus reality. By the time Levi was interviewed for Jones and colleagues’ study he was living well in the world and had a mythos that worked for him. He had successfully used culturally available invitations from the mythical realm of spirits, Gods, and heroes to make sense of experiences that would otherwise be thought of as signs of mental illness.

David had also tried to use the local cultural mythos, albeit not as successfully. As a Black American, David had no doubt received numerous cultural invitations to seek out and verbalize religious experiences. According to the Pew Research Center, Black and Latino Americans nationwide are more likely than white adults—Black even more so than Latino—to say religion is important in their life, to attend religious services, to pray at least daily, to participate in religious education, to meditate, to feel spiritual peace, to read and interpret scripture, and to believe in Heaven and Hell.³⁶ Thus, Black and Latino Americans are likely to

live in social contexts that offer many cultural invitations to use religion or other culturally available mythos to explain events in everyday life. One fine arts scholar, Charles Rhodes, for example, has found that self-taught African American artists often have “visionary experiences” and that “mystical or metaphysical explanations” are common in their descriptions of creative inspiration and methods, most often the Christian God or “some spiritual presence or force directing things.”³⁷

Corrina talked about how her own cultural spiritual experience could amplify her paranoia or be soothing in one of her later interviews:

[T]hat was kind of like the bridge that gapped me being paranoid to me just accepting now that life isn't out to get you. I spun it into something that was positive where it's like, okay, that's God trying to communicate with you, but not literally where you're hearing the voice of God but just that's a connection with some kind of spirituality trying to reach out to you. [. . .] At the same time it's like you have to either try and stay in reality or culturally spiritual. Where, you know, Hispanic people are spiritual, and they believe in stuff like that. So, if I'm gonna believe in stuff like that, I have to stay within the confines of that, and know that—okay, according to this culture and this religion in particular you can claim that you have power over the demons or whatever [. . .] you can also talk yourself out of it if you do get afraid. [. . .] I usually don't get to that point. I usually stay within the stereotypical Hispanic way of seeing it: it's like you can just pray and you'll be okay.

Furthermore, David, as well as the others we engaged, lived in a religious part of the United States. Most Black and Latino persons in Texas report being Christians.³⁸ Perhaps this is one reason why four out of five young people in my study, most of whom were nonwhite, offered my team spiritual or religious explanations around the time of their hospitalization, even though we did not ask them explicitly about religious experiences. By “spiritual” or “religious,” I mean their explanation for their experiences relied on the presence of God, Satan, angels, demons, or the like.

Thinking of themselves as superheroes—secular or religious—helped young people preserve their moral agency at a moment when many other elements of their lives were in upheaval. David's father may have been sending him to his mother's house in another state for better care and psychiatric evaluation, but David knew he was “God's prophet” called to save the world. Amy's family was sending her to a women's shelter, but Amy knew she was really a superhero who could fly. They both developed a way to make sense of what was happening to them at a time when no one else was providing an answer.

Psychologist Jerome Bruner proposed that different cultural contexts offer narrative-based “cultural toolkits” for making sense of the events of everyday life.³⁹ The Western cultural toolkit, he argued, often falls woefully short when used to examine unusual mental events not detectable, measurable, or trackable with the tools of science. As Corrina said, “On the flip side of it, I'm white in this American culture, and we live in 2014 where it's, like, you kind of can separate—I don't

want to say it's not real, but you can tell yourself that's a—you can't see it, you can't measure it, it's not empirical at all." So how to make meaning of experiences like religion, spirituality, and psychosis?

Luke Kernan claims that when there are no cultural containers for experiences of psychosis, a person begins to move away from consensus reality and create alternate realities in their own mind.⁴⁰ Psychiatrist Hans Prinzhorn collected the art of persons who had never been trained in artistic methods but began to make art during a period of unmedicated psychosis. One fine arts scholar has argued that the resulting Prinzhorn Collection "boasts a large number of creators who produced highly individual, alternative world-systems and paranoid 'autobiographies' that are often highly sophisticated," such as in the works of Joseph Grebing (1879–1940) and Jacob Mohr (1884–1940).⁴¹

The youths we interviewed also mobilized culturally recognized mythos, or common recurring narrative themes or plot structures from their own local moral worlds, to relocate their diminishing sense of self in some shared moral understanding or "common sense." This helped them create a sense of belonging, and—while often having the opposite result—signaled their effort to reestablish a sense of trust between themselves and others. Using a cultural mythos as a container for their experiences demonstrated that they were serving a spiritual or heroic purpose, which they hoped might help restore moral understandings about their responsibility and trustworthiness with their loved ones.

But this strategy for restoring moral agency rarely resonated with their loved ones ensconced in consensus reality. Rather, it crystallized others' sense, and typically served as clinical evidence, that the person had indeed made a complete break with consensus reality, that is, experienced a psychotic break. At the time, Corrina, Amy, and David could not understand why their loved ones did not admire their supernatural identities. When their narratives were not validated, things could get dangerous. Corrina destroyed family memorabilia. James parked his car in front of a train. David was arrested in the airport. Amy nearly jumped off a bridge.

User-survivor Sascha DuBrul explained how he used the mythic realm as a coping mechanism for feeling that life has meaning: "It's my protective shell." However, he also pointed out its precarity: "The shaman swims in the waters the schizophrenic drowns in," he wrote in a memoir.⁴² When the waves of psychosis pulled him out too far, "I stop being able to tell what's me and what's everyone else. I start thinking I'm the entire universe—the center of everything. It's so beautiful and glorious until it turns really ugly." It "turns really ugly" when instead of being accepted, the person becomes increasingly isolated by the synergies between their nonconsensus realities and psychosis symptoms.

. . .

So, what if we had a better cultural toolkit, and instead of discrediting people, we used the mythos that was meaningful for them to help support them in crafting a

cultural container that could help them “make sense” of their nonconsensus realities while not discrediting them and this excluding them further from consensus reality? Scattered through the literature about psychosis and psychosis-like experiences are several examples of such options.

In South India, where World Health Organization studies across 30 years found the highest rates of social recovery from schizophrenia,⁴³ Corin, Rangaswami Thara, and Ramachandran Padmavati found that explaining psychotic symptoms was less important for patients and their families than “a more fundamental quest for meaning.”⁴⁴ They argued that as patients’ symptoms came to a head, all concerned were looking for significance in the experience rather than worrying about the label. Meanings around psychotic symptoms were often highly personal but were also often driven by religious signifiers. The flexible use of religious frames helped patients and families in this context shift an alienating experience into a larger, shared frame of reference that transcended the individual by providing “stable reference points” that they could share with others.⁴⁵ This not only “gave direction to people’s lives” but also helped them find a shared ethical quality in the experience.

For example, one man in Corin and colleagues’ study (known only as S2 in their article) had a vision that a man who looked like Moses was near him when he was attacked by a bright light. S2 thought his suffering might be due to his lack of a similar bright light, and he realized that he was being invited by his visions to find one. He thought, I might be “a special person, a saint or something like that.”⁴⁶ He thus began a deeper inquiry into the meaning of his existence. When he shared his experiences with his family, instead of questioning him, his father introduced him to a religious person who became his confidant and adviser. When necessary, S2 withdrew and slept more, so that he could think less and was allowed to do so. The support of his family and the use of culturally salient religious explanations and support from religious leaders had a kind of “reintegrative potential” while also creating a kind of “protective web” around him.⁴⁷ Religious frames helped, and the chosen mythos worked in this situation—thanks, at least in part, to the support of intimate others such as family and respected religious healers.

Another example of a cultural container that seems to help persons with experiences of psychosis symptoms comes from Vilundlela, a low-resource, rural Zulu area in KwaZulu-Natal, South Africa. Here, people diagnosed with psychosis, even by biomedical practitioners, are sent to train as traditional healers.⁴⁸ In this context, unusual perceptual experiences over which sufferers had little control, such as the distressing voices found in early psychosis, are sometimes thought to represent a call by one’s ancestors to become a traditional healer. For those with this calling, special training to become a traditional healer is the only cure. This training, called *ukuthwasa*, is offered by a female “mother guide.” The training involves using traditional medicines (which have as yet not been researched pharmacologically), as well as lessons and rituals (dancing, drumming) that connect one’s unusual

perceptions to the presence of one's ancestors and train one in how to control those perceptions.

Ukuthwasa is regarded as a cure, and initiates anticipate a full recovery and a future social role as a traditional healer. Thus, in this social context, psychosis symptoms become a gift that only increases one's value as a moral agent in a place where those symptoms can be channeled culturally into a life-affirming, socially integrated, and financially lucrative social role. Research suggests that this tradition works for most people: even those who met criteria for a psychotic disorder were able to work as healers and manage their psychotic symptoms in this supportive social context.

Egan Bidois, a Maori healer from New Zealand who was diagnosed with psychosis, argues that interacting with “non-apparent stimuli” is a key feature of traditional healers in his culture—a skill that is passed down through families and must be managed properly for a person to be well.⁴⁹ Bidois manages these anomalous experiences by seeing them as normal and understanding the rules, rituals, and methods that his culture employs to maintain wellness and safety within that experience. He thus works as a mental health counselor and a healer who can cleanse or bless houses and facilitate healing and recovery from spiritual and physical ailments. “That is the role. The function. . . . It is through understanding and accepting that role that strength is provided . . . and I feel much comfort.”⁵⁰

Mad activist Sascha DuBrul designed a kind of cultural container in the United States. He and his friends started the Icarus Project (using the myth of Icarus, who perished after flying too close to the sun), a radical mental health community that promoted face-to-face networks and online spaces for connection.⁵¹ The group also offered “superhero training” to help one another manage what they call the “dangerous gifts” of madness.⁵² Some advice was quite simple, such as limiting cannabis use. Other recommendations were more complex, such as tracking potential warning signs like not getting enough sleep that can signal the approach of unusual sensory episodes; or devising a plan when you are well to help yourself manage symptoms when you are not. Some members of the Icarus Project (now the Fireweed Collective) were committed to avoiding psychiatric medication, while others believed that medications were helpful. Fundamentally, though, the Icarus Project mobilized mutual support groups of people experiencing madness who were willing to help and hold one another accountable.⁵³

Another recent suggestion from the United States is that clairaudients, or psychics who use voices they hear in their heads to give readings—voices they typically attribute to the dead—are comparable to persons with psychosis. One study compared four groups that included both clairaudients who were not receiving treatment for psychosis and persons who heard voices and were receiving treatment for psychosis.⁵⁴ The study found that the two groups were similar in terms of what they experienced phenomenologically and in their performance on psychometric tests. The difference, psychiatric researchers Albert Powers, Megan Kelley,

and Philip Corlett argued, was that for psychics the voices were friendly, could be controlled, and were seen as a gift rather than a burden. In addition, the psychic group's voices seemed to start at a younger age than among the group receiving treatment. In addition, the psychic voice hearers also generally had a positive experience of telling others about their voices—unlike so many in my study. Psychic voice hearers also tended to be less religious and so were not inclined to think they were hearing gods, which may have protected them from developing a more grandiose sense of their purpose. It is striking to me that they were also using the voice-hearing experience as a source of income when they offered psychic “readings” to others for money. At least one person in the study was even becoming a licensed counselor. It does seem that finding a real purpose for the voices is therapeutic. More research is being done in this area as well.

Overall, cultural toolkits can offer a person a sense of meaning, a chance to think positively and value their voice-hearing experience (even if the experience itself was negative), positive connections to others who either share in or value that experience, training in how to manage their experience, and at times the ability to earn income by using their experience. Most young Americans likely don't have these types of cultural toolkits available to them, though, and so they try to make their own mythical meaning without any rituals, training, wise and experienced guides, structure, or mutual support communities. It is then that one's personal mythos—an attempt to exercise autobiographical power and replenish moral agency—can become toxic and isolating. At this point, as Jones, Kelly, Kernan, Kusters, and DuBrul have all warned, psychosis starts to take on its own agency and push people toward more pathological behaviors, as the mythos reinforces socially impairing ideas. Without a cultural container of shared meanings, exercising autobiographical power—in this case, around supernatural explanations—leads people away from the social bases of self-respect and peopled opportunities that they so desperately need to thrive.

Cultural containers help channel the transformative potential of psychosis. When these meaning-making practices lack shared understandings and norms, what could be transformative is instead detrimental to one's relationships. As Margaret Urban Walker wrote, “Lack of shared normative ground means that our expectations are not aligned . . . what you expect from me may no longer be what I expect from myself. . . . In this state of affairs, trust is impossible or is destined to be disappointed.”⁵⁵

At a breaking point, a person with psychosis has such depleted moral agency that they may not even be able to connect with their own mother. Unlike the Indian father in Corin and colleagues' study who helped his son make meaning with religious signifiers and social support and so turned a breaking point into a turning point, most young Americans lack such an option. The American spiritual teacher and Franciscan priest Father Richard Rohr wrote, “If we don't learn to mythologize our lives, inevitably we will pathologize them.”⁵⁶ The youths in my

study seemed to mythologize in order to belong, but instead became increasingly isolated. As psychologist Rufus May observed of his own experience, “People’s wariness toward me seems associated with a fear and suspicion, often prevalent in [Western] culture, toward mental confusion and distress . . . some of my friends were too scared to visit me during hospitalizations.”⁵⁷

Psychologist Stanislov Grof once suggested that a mental health crisis may be seen alternatively as an opportunity to “emerge,” or rise to a higher level of physical and spiritual awareness.⁵⁸ Some social contexts around the world seem to encourage just this conception for some people who are having psychotic symptoms. As psychiatrist R. D. Laing argued, it may be about more than just the mental breakdown; madness may also signal a mental breakthrough.⁵⁹ Put a little differently, and more agentivally, we might see it as a turning point—an idea discussed further throughout the book, especially in chapter 7.

In countries dominated by Western psychiatric approaches, though, many accounts of psychotic symptoms focus on what has been lost—sanity, common ground, consensus reality, shared understandings, trust, responsibility, safety, employment, admiration—the list goes on. Perhaps the loss would not be so traumatic, and the wave of psychosis not overwhelm one quite so much, if we worked with people earlier on to prevent those losses, focus on the positive, and offer cultural toolkits and containers that empowered them to reorient to consensus reality with others rather than struggling alone. As Corrina, James, David, Markus, and Amy have taught us, it is when people get scared and isolated that the real difficulties begin.

We know that early symptoms of psychosis are both surreal and compelling. In the absence of support, they leave a young person feeling self-absorbed, confused, and distracted. They flood the senses with unusual information and unmoor the person from consensus reality. They are self-confirming and disorienting. They create internal loops of ideas and experiences that are both impossible to ignore and difficult to share with others in the absence of culturally meaningful ways to interpret them. This leaves young people with a deep sense of self-consciousness. All of this happens at an age when people are painfully aware of how others perceive them and when they are constantly comparing themselves to their peers.

These experiences strain the moral relationships between young people and their loved ones. Stepping further into nonconsensus reality damages trust between a young person and others. The families of Amy, David, Markus, James, and Corrina were not sure when—or if—they could trust them to be reliable and responsible, which eroded their status as moral agents. But is it possible that early interventions that build on locally available mythos could make a difference if people were trained in culturally meaningful ways to help? Opportunities to intervene can be lost if young persons stop trusting others, stop sharing their experiences, and withdraw further into their psychosis.

Unfortunately, what young Americans with anomalous experiences are offered next are not cultural toolkits for self-understanding and mutual connection, but instead police intervention, hospitalization, and forced entry into a fragmented and inadequate mental health care system (a not-so-accurate label⁶⁰)—which does little to help anyone restore moral agency and social belonging. This is the topic of the following chapter.