*One of my personal goals has always been to write a book. After decades of stops and starts, thanks to Amazon’s self-publishing, “Journeys Beyond the Frontier: A Rebellious Guide to Psychosis and Other Extraordinary Experiences” was published in 2021. Spending many hours organizing what I’d learned over the years about psychosis led me to develop my “Psychosis Triangle”. For those of you who have not read my book, this article is a relatively brief description of the Psychosis Triangle and how using it would lead us to using recovery based programs that are presently largely neglected by our unidimensional approach.*

*When I first described the Psychosis Triangle to my colleagues, most people’s comment was that they thought it would be useful applied to almost all psychiatric disorders, not just psychosis. They’re probably right. In my opinion, this is a conceptualization that really takes seriously, and practically implements, the “biopsychosocial model” we’ve been giving lip service to for decades, while in practice prioritizing only the biological dimension.*

**Overview of the Psychosis Triangle**

**(2021)** Mark Ragins MD

Our DSM definition of psychosis and schizophrenia is unidimensional—it only evaluates people on the basis of their symptoms. Each of their “symptoms” must be put into some context—a context of how they view themselves, their relationships, their community, and their culture. Doing that shouldn’t just be an afterthought—“let’s be culturally competent in our assessments”—it should be imbedded in the way we assess and treat everyone with psychosis and other extraordinary experiences.

Instead of conceptualizing psychosis as a disorder you have in your brain, I’m urging that we conceptualize psychosis as a profound experience that emerges (and resolves) as a product of multiple alterations in function acting in combination, no one of which produces psychosis on its own.

**The Psychosis Triangle**

**Experiencing Reality**

**Self-identity**

**Relationships**

The three interacting dimensions that lead to psychosis are as follows:

1. There are changes in how they are experiencing “reality”—e.g., hallucinations, delusions, paranoia, or spiritual experiences as well as changes in how they process reality like making idiosyncratic connections or relying on irrational “primary process” thinking.
2. There are changes in their internal processing and self-identity—e.g., how they hold themselves together, balancing rational and irrational portions, self-observation, or creating their own stories. It can also include “anhedonia,” the inability to feel joy or pleasure in life.
3. There are changes in how they relate to other people—e.g., disconnected, missing “normal” social signals, hard to relate to, socially anxious, avoidant, or even paranoid.

None of these dimensions falling apart on its own creates psychosis. All three of them must be seriously impaired for someone to become psychotic. Any of the three can act as the initial weak point, putting its neighboring dimensions at risk. Once two dimensions are compromised, the third dimension in the triangle is under severe strain, and if it also falls, psychosis is the result—or it could be a stronghold to rebuild the other two dimensions, leading to recovery.

For example, if someone has difficulties perceiving reality, that can stress their self-identity, but they could contain the damage if they can solidify an identity as an intuitive healer or a voice-hearer. Their relationships will also be strained, but if they can find people who can relate to them and who accept those self-identities and altered reality, the damage may be contained, and their social roles can persist relatively unharmed. While this is an unusual outcome in our society for people with auditory hallucinations, it is a common outcome for blind people, even though their perception of reality is more damaged than most people who have hallucinations.

Although our current medical model conceptualizes all psychosis as beginning with difficulties perceiving reality (and often looks no further), psychosis can begin with any of the three areas of functioning. For example, if someone’s relationships are highly abusive and traumatizing, that can put their self-identity and their perception of reality at risk. If the damage progresses to two dimensions, we call it a personality disorder (with impaired relationships and self-identity) or PTSD (with impaired relationships and perception of reality). But there’s a strong risk that the third dimension will also fall: For example, loss of relationships and self-identity can often make it hard to perceive reality, and severe dissociations and flashbacks can make it hard to sustain a self-identity, as can an unbearable loss that is responded to with denial of the reality of the loss. Commonly the prodromal” period of schizophrenia is a time of deterioration of self-identity and relationships, leaving a person vulnerable to distortions in their experiences of reality.

In my opinion, this is a truly mind-based, holistic, biopsychosocial model with all three dimensions interacting as equals.

Let’s examine each of the three dimensions in a little more detail:

1. Experiencing and processing reality: All of us have a set of senses that bring our minds information about reality—including the usual “five senses,” some intuitive/emotional senses, and even “spiritual” senses. These bring in an enormous amount of information that require rapid processing to put together a coherent perception of the world for us. That processing includes synthesizing the information, combining it with past experiences, and creating meaning. A small portion of this processing is conscious and rational. Most of it is unconscious and irrational. All of these types of processing need to be effectively integrated to create a coherent, meaningful, and hopefully accurate experience. A process this complicated is vulnerable to errors and distortions of a variety of types. Someone may or may not be aware of their own errors and distortions. Many of the most common of these errors—for instance, hallucinations, delusions, paranoia, and changes in time perception—are included within the broad heading of psychosis. Others are included within grief, love, creativity, spirituality, brain or nerve damage, delirium, addiction, and cultural beliefs. In my opinion, it’s important to take enough time to really understand how someone is perceiving and processing, instead of just labeling them as psychotic and moving on to prescribing medications.
2. We all have images of ourselves that we use to integrate our experiences. These self-identities are formed by our experiences of ourselves (and we sometimes struggle when we observe ourselves doing something that doesn’t fit in with our self-identity) and, probably more importantly, by how we see ourselves though other people’s perceptions of us. Other people’s reactions to us hold up a mirror to enrich our self-identity. This “mirroring” begins early when adults make faces at infants responding carefully to their smiles and frowns. It moves on to our roles in our families, our peer interactions, and especially falling in love. It can even continue to seeing ourselves reflected in nature, holy texts, and spiritual awakenings. Once again, there’s a lot of vulnerability in all these complexities. Some people end up feeling like they “don’t fit in” or “can’t connect” or “nobody understands them” or even “I didn’t realize it was abnormal to hear voices until I got older and found out other people weren’t like me.” It can be a serious challenge to form a strong, balanced self-identity—a task many of us keep working at and developing our entire lives. A strong sense of self-identity needs to develop over time and adapt to new stressors. To other people around them, many people with psychosis may seem as though “they’re not all there” or “they have split personalities that change unpredictably” or “they’re lost in their own worlds.” It can take a great deal of acceptance and compassion to give enough empathetic mirroring to people who are that broken to help them grow, develop, and heal.

1. Man is both a profoundly social animal and a profoundly socially fearful animal. While very few people can thrive while living an isolated life, nearly everyone has considerable social anxiety. We evolved in small family-based groups, each one only trusting its own members, developing its own customs and languages to ease connections, and avoiding “strangers.” In today’s society, our relationships are heavily dependent on the roles we have—family, employment, romantic, community, spiritual, financial, etc. Making things even harder, our relationships can be seriously damaged by factors entirely out of our control. People we’re close to can turn on us, reject us, or be taken away from us … and we have to adapt and go on with our lives. Once again, all that complexity leaves a lot of room for things to go wrong. Most people who have psychotic experiences had long-standing preexisting issues in their relationships, often including intense isolation. For many people, the ability to sustain relationships is crucial to the development of and recovery from psychosis.

In contrast with the Medical Model that only focuses on the Experiencing Reality dimension, often sacrificing the other two dimensions along the way, the Recovery Model is open to all three dimensions:

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|  | **Medical Model**  (focus on Experiencing reality only) | **Recovery Model**  (includes focus on self-identity and relationships) |
| Public Health | Mental Health First Aid:  Teaches people to recognize early signs of mental illness, destigmatize, and promote professional treatment | Emotional CPR: Teaches empathic listening, and empowering relationships to help people build their own growth responses to emotional crisis |
| Individual Prevention | Pre-emptive antipsychotic medications for people with family history of schizophrenia, “ultra-high risk” | Headspace: enhances social skills, relationships, and personal emotional skills for youth |
| Early Intervention  “First break” | RAISE: Rapid medication stabilization, using hospitalizations if needed, psychoeducation into chronic nature of illness and patient role, early rehabilitation to rebuild functioning | Open Dialogue: Intensive work with natural social network to preserve relationship and roles while person deals with unusual experiences |
| Intensive Ongoing Support | ACT: “hospital without walls”, multidisciplinary, community-based team insuring medication treatment and life supports | Full Service Partnerships:  Multidisciplinary, community-based team including specialists that support a wide variety of people’s quality of life goals through collaborative, growth oriented partnerships building increasing personal self-responsibility |
| Crisis Response | Police, urgent care, Psychiatric Emergency Rooms, involuntary hospitalizations designed to avoid risk of danger and control people usually with medications | Soteria model crisis residential, peer respite programs designed to give space for people to regain self-control and learning what changes to make to stop suffering |
| Recovery | Illness Management Recovery: Focusing on chronic illness management | Clubhouse, Voice Hearers: Focusing on building positive personal roles and relationships |

The most common “positive” outcomes from illness-centered treatment are someone with repressed psychotic symptoms, but limited self-identity, roles, community integration, resilience, protective factors, leaving them dependent on medications, vulnerable to relapses under stress, and with poor long term health outcomes. The most common “positive” outcomes from person-centered approaches are someone who may have to continue to deal with psychotic symptoms while rebuilding a self-identity, purpose, relationships, and roles, either with ongoing meds (like Elyn Saks and Fred Frese) or without ongoing meds (like Dan Fisher and Mark Vonnegut).