Mental health within higher educations: Challenges and recommendations

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People in the throes of madness need to hold on to some form of peace, like an anchor, while discovering their innermost serenity. The state hospital centre offers no such peace. Even in someone's most tormented nights, consumers armed with the right skills, resources, and support can identify a technique to self-manage their internal chaos and external dysfunction. This article is intended to arm readers with the tools necessary to self-manage their own frustration tolerance throttle. It will provide trauma- and peer-informed insights to practitioners to help patients regulate their thinking and feelings as they tune into their mental status and internal barometer for healthy living after discharge from the state hospital centre. Consumers should feel empowered to always live peacefully and independently, regardless of their chosen path to serenity and peace, even when the world becomes too chaotic to live without medical or psychiatric intervention.

Keywords: mental health; mental health diagnosis; positive psychology; serenity; well-being

As both a mental health professional and a person carrying a diagnosis, I find one term misused and overused; it is tantalising and laden with ableism. The expression is 'high-functioning'. Clinicians use it to categorise and label people whom they feel are doing well and have their diagnoses managed. Most people do not realise that there is no such thing as high-functioning. It is a myth, but one that, without question, is as misleading as it is dangerous to consumers labelled by it. Of course, come people carrying a mental health diagnosis are managing their lives just fine, but this is an entirely different phenomenon. People carrying a diagnosis who are not symptomatic are 'in remission'. There is no high-functioning term thrown around in the DSM-5. Instead, the DSM uses the expression 'in remission', 'partial remission', 'sustained remission', etc. to describe the status of people's active or inactive symptoms.

But somewhere along the road, clinicians and others began using the term high-functioning when talking about mentally ill people. The term, however, does not carry any stable meaning. From clinician to clinician, the term's inherently valueless status means its meaning will shift and inaccurately and ineffectively describe mentally ill person's situation. Clinicians use the term to talk about a person's capacity to work, perform ADLs (activities of daily living), and relate to others, as well as to generally talk about how 'well' a person is doing (Katz, 1983). However, 'well' is not a clinical term. So, why do people continue to use the term high-functioning? I suspect it is rooted in the application of the DSM-IV, which include a GAF (Global Assessment of Functioning) to evaluate how a person manages across different domains of living and how they 'function' in these areas. A low score gestured to a person struggling to perform basic life functions, while a high score signalled that the consumer was managing his illness well. The GAF was not only used to score and diagnose; government agencies and disability determinists use it to rate a person's general prognosis and even predict if they would need government assistance. A low score might award a person carrying diagnosis disability payments, whereas a high score would disqualify them from services.

This is where the myth began to emerge in the field of mental health. The GAF score and its application and implementation in clinical practice were as rife with inaccuracies and misuse at it was unhelpful in determining the real clinical picture of the person diagnoses. Inter-rater reliability between clinicians was low, and the scores were often irreproducible from the same clinician using the scale multiple times evaluating the same person's health at different times with the same health status and client reporting.

In fact, in my conversations years ago with a therapist who was still using the GAF to evaluate my own health in a treatment plan review, I would jokingly ask: 'What is my GAF this time?' Since I was also a clinician at the time, and I knew how ineffective and inaccurate the GAF score was truly was, I would question my therapist's score. If I was scored at a 70, I would say: 'You know, I think I am really 75,' and my therapist would clumsily go over the scale with me, and we would pick out a number that 'seemed' more representative of how I was doing. But in reality, this number was only a marker. Although it was an unreliable diagnostic tool, many government agencies continue to use it to award much needed services like case management and housing services for consumers (Kennedy, Madra, & Reddon, 1999).

The crux of the issue is that the term high-functioning carries with it an assumption that the person carrying the diagnosis is doing just fine. Clinicians, carers, family and friends often use this term to justify the untimely termination of assistance, the elimination of benefits, and the cessation of enrolment in programmes to maintain their progress. Without question, high-functioning patients are left to their own devices after they reach a point in their recovery when they can be independent. This is unfortunate, however, because the result is that many consumers fall back into the system and becomes symptomatic again because they are left to navigate their lives without the helpful programmes and disability assistance they have been accustomed to receive because of their condition.

In many cases, consumers cycle back into the system when they reach a certain point in their recovery and are no longer eligible for services. Chronic patients find their symptoms become active again, often

with greater severity. Without needed services, many patients are at risk of going into 'free fall', because they are not connected to treatment and are supposedly recovered. These patients often fall through the cracks of the system.

To improve the system, we need to fundamentally change the language and the very meaning of word used in clinical practice ("Patients at the Center", 2004). Once the language is stabilised and more accurately used to highlight a person's clinical picture, we can begin to assimilate a new lexicon to talk and think about the way mental health treatment is handled by the experts, as well as by people with a vested interest in a loved one or family member.

Criminalising mental illness

Many online articles, newspapers, at those at mental health forums talk about increasing community violence as a result of inadequate mental health awareness, lack of access to treatment, and uninformed laws surrounding forced treatment. Even more abundant are writings about people with severe and persistent mental illness in the corrections system, often the result of a fundamental misunderstanding of mentally ill needs for rehabilitation. In some cases, mentally ill people are remanded to jail without committing an offence because of bed shortages in psychiatric hospitals. Whatever the reason, people with a mental illness intersect with the courts and/or corrections departments, and the manner in which law enforcement handles and interacts with mentally people must change. This includes the police, judges, lawyers, and people charged with processing mentally ill people suspected to have committed crimes and are therefore under the auspices of criminal justice system for rehabilitation.

One also finds an increase in the number of articles on US school shootings, violence in American university systems, and other incidents. These events are rooted in this fundamental lack of awareness about mental health issues associated with students in general and, more importantly, the developmental and systemic underlying factors that bring university students into crisis. Most students entering university between the ages of 17 and 19 have never been diagnosed with a mental illness. However, there is an important caveat to remember here: Many people suffering from depression, anxiety, and other serious mental health issues. As a result, they fail to get help when they need it since they have never been in crisis before. For most students, living away from home for the first time or even those attending university in their own communities, research suggests that the risk is high for experiencing an undiagnosed mental health disorder (Martin, 2010). For students with a previous diagnosis, secure your mental health services before matriculation into university. Many treatment centres, in rural areas especially, have long wait lists for services and treatment options may be far and few between.

In my case, as student at Binghamton University in upstate New York, I already had an existing diagnosis from high school. Suffering from anxiety and depressive symptoms, I was encouraged to find services in university. Ironically, the important lesson from my university experience was not that my existing illness went untreated. Instead, the problem was the emergence of a new diagnosable condition and disorder. I developed schizophrenia, the symptoms of which in most cases activate in early adulthood (Miller, Byrne, Hodges, Lawrie, & Johnstone, 2002). For most traditional university students, these are the years when people are truly at risk.

Thus, I was connected to treatment, was aware of my existing illness, and knew how to get help when I needed it. But, when my schizophrenia activated in 2008, I was not aware of symptoms and their impact on my behaviour and perception. At the time, I was an English major applying to graduate school. I was also a very eager to learn and connect with professors in the English department. No question, I stood out from other students, in part for the amount of time I spent on campus and in the department offices and in part for speaking with staff or walking around campus all day and into the

night. As my condition developed and I began to unravel, I became even more visible to the staff. Indeed, I was in the department offices so often and behaving so bizarrely that those department personnel connected the Dean and the University Ombudsman to enact a set of rules and establish boundaries for my ongoing presence in the office.

While some staff members suggested I had a mental health problem and, indeed, I was sent for an evaluation to determine if I was safe to continue as a student, I passed the evaluation and returned to the classroom the same day. I was more confused than ever and was also frustrated and angry with staff for suggesting there was an issue with my behaviour. In my eyes, I was simply trying to continue my education after being rejected for further study in graduate school. I thought I was in an unchartered territory. In some respects, I was, because students who are rejected from graduate school are not often already enrolled in the university's undergraduate programme. If they are, the undergraduate programme often signifies the completion of their schooling. I, however, kept going and applied for non-matriculated graduate courses and other classes so that I could stay connected to the University and figure out a path to acceptance into a graduate programme. Retrospectively, even after my recovery, my logic does not seem completely irrational; it was bizarre, and extremely distressing to the staff. I was already on their radar and still was not connected to the treatment I needed so desperately. Instead, I remember vividly that one day, when I entered the English Department office, looked up, and saw the secretary pick up the phone and say: 'I am calling the police.' Believing I was a victim, I did not think the police would do anything or respond to her call. I was wrong, again. Within minutes, I was approached by the university police, who handcuffed me in the department corridor, walked me out of the building, put me in a police car, and took me to the university barracks.

There, I was handcuffed to a pole, crying uncontrollably and very agitated. At the time, if my illness was misidentified and not taken seriously before my arrest, it certainly was not handled well afterward by the campus police I was charged with loitering. It summarises no real crime. Rather, it reveals the mishandling of my mental health. Condition and offers another missed opportunity for connecting me to a mental health service or intervention that could have identified my condition before it worsened. Instead, I was left to my own devices, feeling like a victim and totally petrified of the staff on campus. Even if I thought I had a problem after my arrest, I certainly was not going to the staff to address it. I was left isolated, agitated, and totally without treatment, help, or an intervention by the university that could have halted the progression of my schizophrenia before it developed into full blown psychosis that resulted in state hospitalisation.

On a more global level, however, what happens to students who are not on the campus radar? These are the students I talked about earlier, the undiagnosed high school students at risk of going without treatment in university. Are these students, too, left to their own devices if they are in crisis on campus? I fear for these students, for they are without a voice, without support, without insight into their own mental health, and without access to treatment. Anxiety disorders from stress, depression, and – in cases like mine – schizophrenia, are among a catalogue other conditions for which university students are at risk. They are prone to these conditions because of systemic issues with treatment on campus and developmental organic risk for brain disease and mental illness (Cannon et al., 1994). Although I had a therapist, my illness still went untreated and misidentified; I cannot imagine what might have happened if I did not have any help at all, or if people had not observed my communication with school staff and reported my behaviour at department meetings. While the manner in which the department handled my situation was abysmal, at least it was still handled on some level. Indeed, there was some level of oversight, however, clumsy, regarding the treatment of my condition by staff and my therapist in the community. If I had gone without assistance, as many university students do, this article's conclusion would have been different. But, until universities have adequate mental health services and approach individuals with a mental health diagnosis, or a suspected diagnosis, with dignity and

respect, students will continue to be the very first victims of the society's criminalisation of mental illness.

When I returned to Binghamton University a year later as a graduate student in social work, I visited the English department. The staff spoke of another student who had a serious mental health crisis, but this time the student's situation was handled more appropriately. The extreme nature of my crisis and its unfortunate outcome finally signalled that mental health crises require a different approach than was used with me. Indeed, we learn from our mistakes, at a macro level as a society and at a micro level as individuals. In the case presented here, mistakes were made by both the system at the university level and by individual staff involved with my situation in the department. There is no question that the events unfolding in Binghamton in 2008 and those that followed mirror a larger fundamental problem in our approach to mental health in the higher education system and as people who intersect the legal system as a result of their mental health diagnosis.

First episode psychosis

There are two additional caveats before we apply theory to practice. First, when dealing with the interpersonal world, no level of calmness and serenity can prepare you for what someone will throw at you when they are in crisis and mishandling a situation. In these cases, you may not have to dig deep into your psychological profile to unhinge your frustration. Instead, remind yourself that other people's problems are their own. Feeling or thinking for them will only make their jobs more complicated and difficult to manage independently in the future. The second: Sometimes you should be, or need to be, anxious. Our anxieties are signals that tell us we need to make changes in our lives. If you cannot locate the deep-seated issue, and you know something has to give, sometimes just going ahead without digging too deep into your subconscious or psychological wellspring might provide you with a fast and very much needed change to feel better in the next few moments. The most ornate and complex set and manifestations of symptoms exist in the schizophrenia and related psychosis family of mental health diagnoses (Guttman, 2018). Symptoms are labelled differently to address and explain the experience of the symptomatic person. To identify which is a negative and which is a positive symptom, that is, disorders akin to schizophrenia and related psychosis, practitioners and peers interested in learning about their recovery must distinguish their experiences between an added feature to his presentation and an internal sensation or belief at work in your thought processes. One example is though broadcasting. This is a positive symptom in which a person believes his personal thoughts are available to other people seemingly anywhere in the world (Durham Peters, 2010). It differs from telepathy in that these thoughts are not transmissions per se, but a vast web of shared knowledge among the people listening or accessing the information being broadcasted.

Paranoia

Paranoia is disabling because it limits us by cutting off our world and making us feel uncomfortable to explore and live our lives without fear (Westermann, Kesting, & Lincoln, 2012). Paranoia is fear, and fear stops us from celebrating every moment of our existence. No reason exists to live with paranoia. So, how do we stop it? Eliminate it? The most important place to being is with assessing what you are afraid of and categorising it into three domains of fear. The categories include: (1) letting our small critical thoughts snowball into major fear; (2) eclipsing hopes and limiting our future-oriented thinking; and, (3) combining our fears or apocalyptic projections.

We are critical because we care. We want to manage our lives effectively and precisely. But these small critical thoughts can snowball into major crippling fears that stop us from getting out of bed or being social and making new friends. Why let that happen? Check in with yourself. Self-monitor and find an internal balance with your thoughts. Ever look forward to something? Future-oriented thinking keeps us

motivated and happy about time elapsing or, in plain language, experiencing every moment of every day. Paranoia stops us from experiencing our days because we become so pained that we stop and detach; we do anything to stop the internal fear from strangling other aspects of our lives. The worst thing you can do to make paranoia worse is to combine fears. A hurricane is bad news, but flooding due to high winds and high water is even worse.

Delusional systems

Delusions put the crazy in madness and mental health disorders. This means, simply, that when we think he is 'out there' and 'nuts', we are referring to the delusional systems within a person's larger set of symptoms. Delusions carve out the imaginary and marry it with our orientation in various ways that complicate and distort our reality and sense of self (Jeannerod, 2009). When we say someone is delusional, clinically we mean someone's ideas and the beliefs they hold about their world are more than just unusual, they are a departure from reality. What is happening internally is not congruent with the external world. Usually, with most mental health disorders featuring psychosis, delusions are more abundant that one isolated, disordered thought. Delusional systems are either fixed or solvent. This means that no matter how a person's recovery progresses and how much external world changes, the delusion persists. This post targets how delusional systems are born and evolve in the person experiencing an altered reality and what the implications are for practice and treatment.

A delusional system is not complex when first born. In fact, it may be as simple and benign as a newly formed idea or routinely repeated habit executed internally by a person trying to complete their ADLs or go to school or work. For example, a person might be cleaning wax from their ears when a switch flips in the brain and slowly, seemingly organically, the thought transforms. Suddenly, and conversely over time, the person cleaning the ear is no longer purposefully removing was, he is doing something different and likely more malignant in design than when the idea was first executed by the brain. In my own experience, when I first experienced the birth of a delusion it was my relationship status with a friend and, ultimately, marital status. At one moment I knew myself as single. Then over time, and yet suddenly, I knew of myself as married with a child on the way, depending on the health of my friend's womb and a piece of fruit on my windowsill that I connected to the health of her uterus. This is an example of how distorted thought can evolve into a complex system with both fixed and solvent features.

How a delusional system develops directly informs how clinicians should take it apart in treating the person with altered realities. Since delusional systems develop over time and are realised suddenly by the person experiencing the change in their external world, the clinician must identify where and when the 'break' or shift occurred and what that meant for the person experiencing the shift in reality. For example, if a person, over time, thinks a microchip is implanted in his brain, the clinician must identify when the break originally occurred for the person and what it means to experience the symptom. This means, similar to performing a maths equation, that charting the clinical picture's distance from the shift in reality in terms of each aspect of their mental status (e.g., time, place, judgement, insight, etc.) is the first step in unwinding the delusional system's content and breaking fixed-thought structures into less toxic and maladjusted patterns.

I experienced this symptom firs-hand during my final days in the community before I was hospitalised for full onset of first episode psychosis. This symptom is not so much scary as it is confusing and disorienting. I was driving down a major interstate when I first heard my thoughts and believed they were being listened to by friends and family, who were actually hundreds of miles away. However, when experiencing the symptom first-hand, I felt as if my family could hear my thoughts immediately and without regard to space or time. I could even hear the beginning of their responses to my transmission if my imagination or subconscious really had a choice about things. In this sense, voices

and delusions collide together to make this feature of psychosis even more difficult to experience without breaking from reality. The break is not a sharp departure in orientation, but rather noise and interference of thoughts; the addition of these positive symptoms and the space needed to hold on to this overly complex delusional system takes time to process information effectively as it occurs. This is why very psychotic people speak slowly, and their reaction time is longer; there is so much more to process to maintain even basic life functions. So much is happening or not happening in the person's speech and language centres in the brain that the person experiencing the symptom must sort out the overabundance of stimuli to stay connected to the world without getting lost in internal preoccupation.

To broadcast thoughts, the person transmitting must be listening. Since thought broadcasting is a symptom and non-existent under normal circumstances, the person must acknowledge that it is happening as it happening. Thought patterns that are too involved and overly complex are even more diffused and difficult to decipher as either real or a symptom of illness. This is why, as this symptom progresses, people get increasingly lost in internal preoccupation and are unable to come out of their heads per se and spend their time just listening to or even responding to his internal thoughts externally or aloud. This is when you typically hear of people responding to attention or appear bizarre to others. Since this also occurs late in the progression of the diagnosis, people experiencing the symptom are usually already in the hospital. Without experiencing this symptom, it is hard to believe it can happen to a person. I solve the mysteries already at work from a growing delusional system. In my case, I was driving. You may be walking the dog. Just be safe in any event and remember safety is first and foremost the goal when you begin experiencing something so otherworldly and yet so personal that it breaks the very conventions of time, space, and communication between people subject to physics and human anatomy.

The final night I was hospitalised in the community hospital, I heard screaming all night long from my neighbour's room. She was carrying on like a child. The screams resembled those of a baby's cries. I kept pressing the button next to my bed to summon staff, but nobody arrived until the next morning. Given the sleep deprivation and my compromised mental status, I was delirious at this point. By the time the staff from the unit was in my room addressing the situation, I was feeling so nauseous from the noise all night that I leaned over and vomited on the social worker and lunged towards the psychiatrist for help. I was immediately placed in the quiet room to be monitored and assessed for safety every 15 minutes until I was stabilised. About an hour later, the doctor came into my room and advised me that I would be transferred to another hospital and that I would be staying there for a very long time. We all have limitations. Some of them are more visible to the naked eye; others are more covert and hidden from the public but still an internal struggle we battle every day. As a therapist, I have the opportunity to listen to other practitioners talk about their patients and their ideas on how to help them in their treatment.

Mania

Sometimes my head spins from the ideas circulating around the table; hopefully, now it will be clearer to practitioners what treatment fit means in the context of supporting people in their healing with functional impairments. Mania can seem like the best high in the world and must be undersold as an affective state impairment in functioning of all shapes, sizes, and forms. During a manic episode, you can transcend historical points of reference and religious symbolism/iconography prescribed by your belief system and finds yourself incorporated into it despite anachronistic markers, which should signal a problem with your perception. In this case, mania will, in fact create a new reality, if only for the moment, and shift your guidance into a space that will seem like anything is plausible when something is very wrong with your affective regulation. I have experienced first-hand manic episodes in which I have been awake for weeks at a time without sleeping or needing rest. I have witnessed other people so dysregulated from mania that they would do somersaults across the floors of the psychiatric ward just to find their bodies would later feel the shock of these poorly planned acrobatic theatrics. With certain

diagnoses, manic symptoms become more difficult to identify. People carrying diagnoses that include psychotic symptoms should pay even close attention to their moods because psychosis can worsen with extreme elevations of mood. This then further complicates a person's insight, as well as the judgement of their symptoms. For most generic mood disorders, extreme euphoria, decreased need for sleep, hypersexual arousal, and religious ideation are the usual suspects when manic symptoms are present. Should these symptoms activate in a subclinical or mostly unproblematic manner, in your life, you may be working with hypomania (Bowen & D'Arcy, 2003).

In terms of self-management and self-regulation, several options are available for reducing the harmfulness of a manic episode on your interpersonal life and your capacity to execute activities of daily living without incident. These strategies are dependent on the manner in which mania was activated and how severe your symptoms are. Stimulant- and drug-induced mania is just as dangerous as organically-driven manic episodes. Considering substance abuse treatment for cases like this will be an important step in managing your symptoms for the long haul (Burden, Pilao, & dela Rosa, 2018). Like most people, even minor stimulant use from caffeine can trigger an episode. Living a chemical-free lifestyle is not for everyone, but it can provide a baseline, at least temporarily, with which to gauge further consumption of foods and beverages that might trigger an episode. For non-chemically induced episodes, internal and external barometers are essential for knowing your affective state baseline. Listen to your friends and colleagues; maybe recent complaints have been made about your behaviour, or maybe your feel like it is challenging to maintain a balanced mood. You may also begin to create markers in your living environment.

Creating a plan for friends and family will greatly reduce the risk of potential harm from an episode. This means making friends and family aware of your symptoms and triggers so they can help you avoid the ups and downs of mood dysregulation and even help you make decisions if your judgement and insight are too impaired for rational decision making. I send emails to friends and family when I feel like my moods may be impaired or have impaired my decisions or, in the future, might harm others. Preparedness and attention to details are always essential when managing an illness. Surround yourself with supportive people and allies in your recovery. You should never feel embarrassed by your behaviour, but you always need to accept responsibility for it. That is how recovery works: acknowledging that change is necessary and moving forward in the process of adapting our behaviour until it serves our purposes.

Stilted language and word salad

Anyone who knows me personally or professionally is ware of my love of language. As a person diagnosed with schizophrenia and a lover of language, the road to recovery and symptom stabilisation has been difficult and frustrating. Schizophrenia impacts the speech centres and hemispheres of the brain. I passed through several phases of speech problems, some more observable than others. This article will focus on two common speech-related symptoms people with schizophrenia experience: (1) stilted language and (2) word salad. I will tie in my own lived experience with these symptoms and my experience treating the disorder as a clinician with experience in chronic disorders and serious and persistent mental illness.

Schizophrenia and psychosis-related symptoms worsen over time. When I first began experiencing each of these symptoms I was a university student studying English and rhetoric. Just to give a little background, I was always a bit pompous even before my schizophrenia symptoms became active. As a student studying English, I liked to use language that was extraordinary and heightened above the common colloquial of university students and most native English speakers. When my symptoms began to activate, I was preparing for my last year at university and my brother was getting married. As the best man at his wedding, I had the honour of writing the wedding toast. Given my love of language, an

already elevated vocabulary, and knowledge of rhetoric from years of study, I wrote then what I thought was a great wedding toast. But upon reflection, and the timing of the activation of my symptoms during my final year of university, I truly believe that my choice of wording and rhetoric was impacted of my symptoms.

The wedding toast is a great example of stilted language. The toast itself was written in the style of Jean-Paul Sartre. At that time, I was very much interested in literary theory and philosophy of language. I had also just finished reading *Being and Nothingness* and wanted to put theory into practice. The toast talked about my brother's relationship with his new wife and its evolution. I thought that their history together would be perfect material for a toast. So, I talked about how their relationship evolved from nothing into something. The toast followed this theme and in one great crescendo, I launched into the metaphysics of all of it – their relationship and how this phenomenon yielded the very wedding I was toasting. I also remember reviewing multiple drafts of the toast with my parents before finalising the version I read at their wedding. To be quite honest, every memory I have of speaking and using language after the wedding until I was finally hospitalised for full blown psychosis was stilted and gradually more pompous, flowery, and excessive. Ultimately, it became unrecognisable and incoherent.

This is when the word salad emerged, and what was a catalogue of symptoms activated was. By the time I was in the hospital, I could not speak recognisably. Indeed, I suffered a major deficit in language and a loss of it altogether as my symptoms worsened. However, the language I was using to communicate was jumbled to say the least. The syntax, word order, and sentencing structure of my spoken word 'choice' were all over the place. In the hospital, I had a very had time communicating with staff and even worse, my needs at the time due to these language issues. There were other speech issues too, as I experienced many of them because of the activating psychosis. Indeed, I was experiencing perseveration and echolalia, which is when a patient repeats the language of staff or people around him instead of communicating an original message (Cuesta & Peralta, 1999). The worst symptom was the word salad, mostly because nobody knew what I was talking about. Given I have all my clinical records from the unit; I have gone ahead over the years and reviewed the staff notes, as well as my own writing on the unit. I observed a trend and common degradation of language from the time I was first admitted to transfer to the state psychiatric centre for unresolved psychosis. As time passed and my length of stay increased, symptoms such as word salad and stilted language also became more intense and more visible in the records. Similarly, my situation on the unit, condition, and prognosis worsened.

Hindsight is 20-20, or so the expression goes. Sure, looking back today I am able to identify these symptoms, chart their frequency and intensity over time, and evaluate my overall condition. But back then, all of this was news, and I was working in the unknown. Many people who experience these psychosis symptoms do not realise they are even experiencing them. This can be the result of the gradual progression and onset, which is hard to self-identify in the moment and over time (McGlashan, 1999). Even as a clinician, I can make mistakes in early detection with my own patients and the activation of their psychosis symptoms. Certainly, in my case, these symptoms seemed normal until I became too detached from reality to understand how disconnected I was to the world around me. I was disconnected by language, above all, and then, ultimately, by perception, which only further complicated my capacity to relate to others in a meaningful way. To this day, my speech continues to heal, and I am being more vigilant these days about the quality and content of wording and status of my language.

Let us be completely honest about healing after discharge from the state hospital centre. Depending on the functional impairment or limitation in completing self-directed tasks to maintain a standard of living and quality of life after discharge, treatment plans to address interfering symptoms are only the beginning when it comes to complete recovery. Depending on the goals of the individual, the interfering symptoms should not be the focus of treatment. Instead, focus on strengthening the weak points in

functioning, regardless of the particular symptoms blocking the person's ability to maintain a desired quality of living. Interfering or unresolved symptoms can be treated, but they are certainly should not be the focus of treatment. Some people never experience relief from their symptoms because of extreme chronicity and untreatable impairments. Not every symptom is rooted in a diagnosis; sometimes, flaws in our personalities govern the expression of our limitations. We need to refocus treatment to target and identify the weak points in a person's functioning – whatever the symptoms are that block abilities and create impairments. I have seen first-hand clinicians and peers dwelling on unresolved and chronic symptoms as if strengthening a person's weakness in functioning would not help them move forward in their healing.

DISCUSSION

I have said there is no universal way to capture or express the experience of psychosis. I might be incorrect in this claim. This all depends on your definition of capture and experience. Therefore, to determine the validity of my original statement, I am going to suggest the following new three-part theory surrounding the study of psychosis and its application in practice: (1) the accumulation of psychotic symptoms and the worsening of psychosis symptoms is rooted in the changing of signs within a person's system of signification; (2) although the identification of psychosis symptoms does not mark or capture a sign, the worsening of corresponding, primary, residual, or inactive symptoms can be portrayed as a wholesale changing of a person's experience in reality; and, (3) this occurs through a fundamental restructuring of a person's won interpretation of their system of signs, in language, oral expression, and all brain functions that interact with the world through use and passage through his interpretive eyes.

The term universal definition means 'common effect' (e.g., noun) or 'applicable to all case' (e.g., adjective) if we analyse both the structure of sentencing in a linguistic breakdown universal of both meaning and usage. The point of departure for defining 'universal' also makes visible the multiplicity inherent in the world. In fact, this applies to all words, especially when they are analysed for both meaning and usage. No doubt, signalling the instability of a common signifier o even effect is both neutered and more rightly highly suspect. What I mean is that, as the number of common signifiers increases in any given system of signification, the likelihood, or odds, of a common effect being experienced by people in crisis and going through the throws of first episode psychosis becomes more and more unlikely. Given the projection of worsening psychosis symptoms and the uniqueness of each experience, the chances of any person seeing, hearing, feeling, or smelling something the same way as another person is totally implausible.

Psychosis symptoms can serve as the body's response to a life adjustment. In doing so, the mind creates a maladaptive coping mechanism. This is not to say the organic brain disease is a coping mechanism. Rather, the manner in which the body compensates and handles the change in brain function is in essence both a method of coping and adapting to something altogether harmful for the body. The change in brain function is what I am suggesting problematic. The body's response involves coping with the interpretation of their own system of signification is healthy to a point. Sometimes, the mind needs to deal with the dysfunction of its regulation by systematically changing its signs. I fully believe during initial psychotic symptoms, the early moments of a person's break are generally experienced as more systematic in terms of the composition of the changing sign itself. I am suggesting that before psychosis symptoms worsen, they will shift from more systematic sign changes to more disruptive, arbitrary, and altogether difficult-to-follow changes within a person's system of signification and own interpretation and connection to the world; this makes sense. As brain tissue becomes more damaged, neurons and their pathways will become more misaligned and signals to and from the brain more chaotic and dysfunctional. This is to say that before things get really out of hand, therapists can measure the rate of

change and introduce measures into the worsening of psychosis symptoms by charting and mapping out the rate of change within the person's system of signification.

The clinical significance of these claims has potential. If we assume my claims regarding the experience of psychosis can be measured, mapped out, and analysed for degradation between linkages of signifiers, the usefulness of this scheme becomes clear. Further analysis will have to research the correlation between sign linkage and the experience of the individual suffering from psychosis. Given all signs are going through changes, with the active disease process also assumed to move towards a higher degree of chaos instability, measuring distress tolerance to such changes will also be necessary to the research to add full meaning to understanding how everyone's unique experience shares commonalities.

Psychosis is experienced by people carrying its active constellation of corresponding and altogether unique symptoms differently. At different times, along a spectrum, psychosis symptoms exist in a dark harmony, sometimes feeding off one another and sometimes working in complete isolation. The spectrum intensifies in many cases over time upon initial activation. The spectrum of psychosis symptoms delineates how the symptoms are experienced individually, that is the timing, triggers, age, and developmental circumstances (Kuha, Keawkubthong, & Relojo, 2018). around the symptoms activation and life circumstance. The intensity of the corresponding symptoms, their subsequent manifestation into behaviour, and their possible impact on a person's mood are also all individuals. Almost every aspect of how psychosis is experienced is individual to that person. The only universals are how the symptom is clinically treated, how our society handles people actively experiencing the symptom, and our view and biases that go along with people in crisis as a result of unmanaged persistent psychosis symptoms. What is not talked about too often is the otherworldly nature of psychosis as its first activating. There is certain mystique to psychosis. Indeed, psychosis does distort how we perceive reality and plays around with our level of attachment to the world. But, without question, for people in extreme situations, unusual situations, experiencing a new or reoccurring crisis, and bizarre situations which complicate our existence as we know it, the introduction of a new angle or worldview can sometimes be very exciting and seemingly needed to pull ourselves out of a holding pattern. The symptoms impact on the individual may indeed seem welcome, timely, and necessary to experience a needed change.

CONCLUSION

My psychosis symptoms activated at the very moment I needed to experience a change and adjustment in my life, in now I interacted with the world and in how I understood it. Indeed, when a person needs to make an adjustment or life change, activating psychosis symptoms can paint the world in more palatable colours, and perhaps even shift perception enough to identify alternate and new solutions to existing problems which continue to persist because you have not been able to step outside your own perspective. Job loss or unemployment, relationship changes, and major life circumstance adjustments are very difficult to tolerate. Indeed the DSM-5 diagnosis of an adjustment disorder exists as primarily the pathway to greater more complex issues if we let our problems go unresolved for long periods of time. Given people experiencing and adjustment disorder are unhappy with how the change feels or how it impacts the thought process, our behaviours may ultimately be impacted by the distress involved from whatever trauma we are passing through in the moment. Thus, the brain goes ahead and activates psychosis symptoms so the body can more easily tolerate the change without feeling or thinking about the problem as intensely and as painlessly as possible. There is a reason why homeless people suffering from psychosis usually became psychotic after they lost their homes and need to adjust to life on the streets. People who go through major life adjustments can take solace and comfort in the initial stages of psychosis.

Psychosis and how the individual is ultimately impacted will be different for each person, but over time and in the presence of additional stressors, the symptoms worsen and become unmanageable. So, the

gradual and welcome shift in perception will seem and feel welcome for a while, but, if the same stressors continue to aggravate, agitate, and feel welcome for a while, but, if the same stressors continue to aggravate, agitate, worsen, or persist, expect the detachment to increase, and a sharp departure from reality will be in your cards in the near future. For the person adjusting to life on the streets or going through a tremendous loss, the mind will accommodate whatever the person needs to do to cope with their new reality. Sometimes, the mind does not work the way it should. In the case of psychosis activating, it may seem to work for a period of time, but ultimately, the symptoms are overwhelming and become so profound that life becomes too distant and unrecognisable to live without incident. I am suggesting that initially, some variance in our reality may seem appealing, but as the symptoms worsen and become more extreme, the interplay between our already stressed situations and our bodies' response to the stress is overwhelming, disturbing, and scary to experience. There is no question that those of us prone to psychosis becoming active or reactive chronically understand this mystique about the way our bodies experience this response to whatever we want to escape from or sometimes forget because it is so traumatic or just worth forgetting.

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