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Interview with Dr. Tanya Luhrmann, Stanford University Albert Ray Lang Professor of Anthropology, Professor of Psychology by courtesy

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Dr. Tanya Marie Luhrmann is the Albert Ray Lang Professor of Anthropology at Stanford University, with a courtesy appointment in Psychology. She earned a bachelor's degree from Harvard University and an M.Phil and PhD from Cambridge University in Social Anthropology. Her work focuses on the edge of experience: on voices, visions, the world of the supernatural, and the world of psychosis. She uses a combination of ethnographic and experimental methods to understand the phenomenology of unusual sensory experiences, the way they are shaped by ideas about minds and persons, and what we can learn from this social shaping that can help us to help those whose voices are distressing.

She was named to the American Academy of Arts and Sciences in 2003, received a John Guggenheim Fellowship award in 2007, and elected to the American Philosophical Society in 2022. She has published over thirty OpEds in The New York Times, and she is the author of Persuasions of the Witch's Craft, The Good Parsi, Of Two Minds, When God Talks Back, Our Most Troubling Madness, and How God Becomes Real. She is currently working on a book titled *Voices*.

For this interview, *Pathways* sat down with Luhrmann to talk about her fieldwork experience with Americans experiencing schizophrenia, and to discuss the implications of her research on mental health policy and care in the United States.

How did you get into thinking about mental illnesses shaped by culture?

My dad was a psychiatrist, so I grew up with many stories about psychosis at the dinner table. I was always interested in the experience of consciousness and the way that consciousness is shaped by conditions like psychosis, and how that is alike and different from ordinary consciousness.
I wrote my first book about middle-class people who practice witchcraft and magic. What I noticed was that people were more interested in what they experienced than in what they believed. They had these strange experiences that were so interesting to me.

Then I wrote a book about psychiatry that took me into psychiatric settings. I was trying to figure out how to think about modern psychiatry and about two different ways of thinking about mental illness, one more biomedical and one more psychodynamic. As I was doing that, I realized there were people experiencing psychosis, and I thought it was fascinating.

When I finished that book, I started doing two kinds of projects. I was going into churches and temples, trying to figure out how people experienced God. I was also spending time with homeless, psychotic people on the streets of Chicago. I became interested in voices because, in both settings, people talked about voices. People who are psychotic often have hearing a voice as one of the dominant experiences in that world. In religious settings, people talked a lot about hearing God's voice. I became interested in understanding how those were alike and different.

One of my colleagues told me about a conference in Chennai, India, on schizophrenia, and I started going. A colleague suggested we do a project together. I should talk to people who hear voices in that culture and compare them to people in the US who hear voices to see what happens. I began doing that, and it became all engrossing.

One thing I was thinking about is that in collectivist cultures like India, people might have a less negative experience of hearing voices. It might not necessarily be as bad. I'm curious whether you think that perspective could translate into the US to shape the way we treat mental illness here.

I think it's clear that cultural setting makes a difference in how people with psychosis experience their voices. In this culture, many people know that hearing voices is a symptom of schizophrenia, and they're afraid of that word. It is hard to change that because it is a common piece of culture. Often, people do not do anything about the illness until they find themselves in a psychiatrist's office. Then they develop the sense that hearing voices is a terrible thing. We do not have many ways in this culture of making sense of voice hearing, unless you are in a religious setting where people are more flexible with vivid experiences. If there were a way to help someone beginning to have symptoms develop a richer understanding of what might be happening to them, that would be better.

Someone with psychosis once told me, "When I started to have these experiences, I did not know that I was ill. Then suddenly I was in a psychiatrist's office, and they told me I was hearing voices. That did not feel like a good description of what I was experiencing. I knew it was bad, and I felt terribly lonely." She said, "I felt like no one understood me. Even the person who thought he understood me did not understand me." If there were a culturally gentler way of helping people who are beginning to have these experiences understand them, that would be good.

There are also culturally sophisticated treatments for psychosis that are helpful. People who hear voices often feel alone. They think no one understands them and wonder if anyone has had these experiences before, even if they know intellectually that one in 100 people meet criteria for the condition. It feels lonely.

There are groups called hearing voices groups where people who hear voices come together and talk about what is happening. You can do more technically sophisticated things in those groups. You can encourage people to talk to their voices, which is called voice dialogue. You can ask people to map their voices. They might say, "My dominant voice seems like a man in his forties. He says his name is Frank. This is the kind of thing he says to me." Even if you do not do that, just having people sit together and talk about their experiences often makes them feel less alone. I think that is very helpful.

Where do hearing voices groups typically occur? In community spaces?

Often, they have an online presence. There is a website where people can learn what is available in their area. Psychiatric programs in hospitals may know about them. There is also an international organization and a national organization. In-person groups are denser in big cities and less common in smaller cities. Many online groups emerged during COVID, and now many groups are run online. That means no one has to travel far. A colleague of mine is studying these groups in Los Angeles at UCLA, and their groups are on Zoom. Someone I know in New York attends a group on Zoom as well. That makes participation easier.

As you're saying this, it makes me think about how people are using AI as a therapist in places where they cannot access one. Do you think AI might develop as a way to help these groups?

There are treatment techniques that resemble that. Hearing voices groups depend on other people. Another treatment is called Avatar therapy. A therapist works with someone who hears voices. The patient chooses an avatar to represent their most difficult voice. The avatar is animated. The therapist controls what the voice says, but the patient describes what their voice says. For example, the voice might say, “You are worthless. You do not deserve to occupy space.” The therapist programs the avatar to say that. The patient knows they are looking at an avatar, but it speaks the words of their voice. The therapist appears in a small box on the screen and coaches the patient to respond. The therapist may say, “Now tell the voice that you are not worthless.” The therapist also manages what the voice says so it becomes kinder and more socially appropriate. People respond differently, but some are helped. Later, when they experience their voice outside therapy, they can engage in dialogue with it.

Is there a spectrum of hearing voices? Do some people hear them occasionally, while others hear them constantly?

There is clearly a spectrum within schizophrenia. It may not have a single cause. Among people who meet diagnostic criteria, there is a wide range of experiences. Some hear voices constantly. Some do not. For some, voices come and go. Over a lifetime, there may be periods when the voices are mean, loud, and difficult, and other times when they quiet down. Stress often plays a role. Some people age out of certain symptoms.

People with post traumatic stress disorder or dissociative identity disorder sometimes report voices. Trauma plays a significant role in those conditions. I think the quality of those voice hearing experiences can be different. They are often richer and more narrative-driven.

There are also voice experiences during high fevers or drug use. Sometimes those voices are similar, sometimes different. There is still much we do not know.

Are voices shaped by the people around you? My mom says the way you talk to a child becomes the voice in their head later.

Voice is a broad category. All of us have inner voices, but there is a wide range. In the general population, there is great variation in whether inner experience involves many words, images, or neither. Some people experience sensation more than language or imagery.

Some inner voices feel stronger and less like you. Sometimes people can learn, through practice or experience, to recognize that certain thoughts do not feel like themselves. For some, those experiences can begin to feel as though they are outside the self.

I do think much of our inner experience has a template laid down in childhood. I tend to think that inner experience is shaped by internalizing external experience. So what happens in childhood matters. How emotions are managed matters. What emotions or words are remembered or suppressed matters. These are big and important questions.

Could you tell me more about how you began working with unhoused women experiencing psychosis and what that was like?

It was hard at the beginning. I had written a book about psychiatry as a profession and had begun exploring psychosis. I felt I needed to talk to patients directly. I was introduced to a man who had been named mental health person of the year at a hospital. He was well put together but had unusual experiences. He introduced me to his friends, and we would sit and talk.

I decided to explore a practical problem: why some people with serious psychotic disorders do not want housing even when it is available. These are people we describe as homeless or unhoused. There was an area in Chicago where many services were clustered. Sociologists sometimes call it a service ghetto. People could get food, dental care, and sometimes shelter. There was a drop-in center for women where no money or diagnosis was required. Around 80 percent of the women there would likely meet criteria for a serious psychotic disorder. People were often very ill.

I would go in, sit at a table, and start conversations. If someone did not want me there, I would leave. At first, it was difficult. People who are very ill may not engage in typical conversational ways. Their facial expressions can differ, and they may not follow ordinary back-and-forth patterns. Over time, I adjusted and found my way. I began dressing and speaking differently and was more accepted.

What surprised you most?

I realized how hard it is to be homeless. That sounds naive, but I did not fully grasp how violent it could be for these women or how much protection they needed.

Some women received disability payments, often around $600 a month. There were men who targeted that money and formed exploitative relationships. I saw that having a reputation for being aggressive or unstable could serve as protection. People would make themselves seem bigger or more intimidating when approached by strangers.

I was also struck by how pride could make someone refuse housing. In that neighborhood, people saw individuals who were flamboyantly psychotic and vulnerable to being beaten, robbed, or assaulted. They believed only weak people went crazy and that once you went crazy, it was permanent.

There was a large hotel called the Somerset, where people with serious psychotic diagnoses could get housing. I would hear women say, "I am not going to the Somerset. I am not crazy. I do not need their housing."

Some clinicians believed people refused housing because they lacked insight into their illness. I saw that some did have insight, but did not want the label.

Do you think the most severely ill people had a genetic predisposition, or was it experiential?

Schizophrenia appears to involve genetic vulnerability and is likely polygenic. There are probably multiple entry points into the illness. When people are very ill, they look similar across cultures.

Neuroscience suggests multiple vulnerabilities. Home environment matters. Being born poor increases vulnerability to many difficulties, including psychosis. Being bullied or repeatedly stressed increases vulnerability. Life experiences interact with underlying neural and psychological processes, shaping how symptoms develop.

There are likely many interacting pathways that contribute to what we call schizophrenia.