Therapeutic Uses Of The Experiential World Inventory

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The Experiential World Inventory has been demonstrated to be a valuable diagnostic instrument, tapping an area of the patient's perceptual world which was inaccessible to the clinician prior to the development of this test. It has been shown to be a reliable, valid measure of the subjective experiences of the mentally ill, and provides the clinician with essential information to be used in treatment planning and evaluation. The present paper describes some new techniques which we have developed, in which the EWI is used as the basis for expanded diagnostic methods, interviewing, treatment monitoring, family and individual psychotherapy, and patient education.

The EWI was inspired by its predecessor, the H.O.D., or Hoffer-Osmond Diagnostic Test (Hoffer, Kelm, and Osmond, 1975), which Dr. Humphry Osmond has described as having an intriguing history (Osmond, 1974). It seems that Drs. Osmond and Hoffer were in search of an instrument which would catalogue the perceptual experiences of their patients so that they could know exactly what was happening to these patients. They requested such an instrument from their psychologist colleagues and were told that no such test existed, and further that such a test would be very difficult indeed to construct. These two ambitious doctors fortunately chose not to take this word as final and decided to construct their own test. The result of their efforts was the H.O.D. Test, a card-sort instrument consisting of actual statements of patients about their distorted perceptual worlds. The H.O.D. Test was the pioneering effort in mapping out the experiential worlds of mentally ill people, and proved to be a useful instrument for those clinicians who wished a view into the special worlds of their patients.

After using the H.O.D. for some time and finding it effective and useful, Dr. Moneim El-Meligi decided to construct a test which was properly designed according to psychological test construction principles. He selected approximately 1000 new items from books on psychedelic experiences, from his patients, and from his philosophical reading. From these items he chose a final 400 items to which he applied psychological norming and standardization techniques, and the result was the Experiential World Inventory, a two-part inventory of experiences which commonly occur in mental illnesses. The inventory consists of patients' statements about their experiences, and can give the user of the test valuable insight into what is happening to' a patient with regard to sensory perception, perception of others, ideation, euphoria and dysphoria, and other experiential realms. When used for diagnostic purposes, a profile is obtained which can be compared against the profiles

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of patients suffering from various illnesses. The test is a reliable, valid, clinically useful measure of perceptions, thoughts, feelings, and volitions. Its use has been described in the original manual (El-Meligi and Osmond, 1970) and more recently in a special manual incorporating computer methods in administration and scoring (Bisbee, Mullaly, and Kuechenmeister, 1979). In addition to its original purpose as a diagnostic instrument, the EWI has proven to be a valuable aid to other therapeutic processes as well.

Diagnosis

We have expanded the uses of the EWI in diagnosis beyond the methods originally devised, and have found it to be more useful than traditional tests, as well as extremely useful in combination with other psychological tests such as the MMPI. The typical use of tests in diagnosis is to give a sufficient description of the patient's condition to classify the illness according to the categories found in diagnostic manuals. The EWI can also be used in this way, as the configural analysis of the scales yields enough information to classify most illnesses according to diagnostic categories. The expanded use of the EWI in diagnosis makes use of the individual items from which additional information for diagnosis is obtained. Not only can the diagnosis of schizophrenia be made from the profile analysis, but also, a full description of the individual patient's perceptual anomalies can be obtained by examination of items answered in the pathological direction. In manic-depressive illness, the entire excursion of ups and downs can be mapped out, from the early stages of the cycle to the obvious psychotic states. The anxieties of the neurotic and the overstimulation responses common in personality disorders can be observed. This description of illness in terms of symptoms is important to the patient and family who may not have an understanding of diagnostic names and categories. While a simple diagnostic name is important to the patient, a complete description of symptoms which accompany the diagnosis is even more meaningful and useful.

Interviewing

We have found it most useful to follow EWI testing with an interview session, in which we discuss with the patient those items answered in the pathological direction. The purpose of this interview is for clarification and refinement of the items, and to allow the patient to expand on the experiences and thus give additional, valuable information about the experiential world. We have found, for example, that "false positives" can be ruled out through this kind of interview. In some cases patients will answer in the pathological direction to a large number of items, leading the examiner to conclude the presence of a psychosis. However, upon interview, it will be discovered that the patient has answered very freely to these items, and that the items can be taken as exaggerations of normal circumstances. An example of this kind of answering occurred when a patient answered "true" to the item, "I sometimes think other people's thoughts," but in interview stated that this answer referred to those occasions when she was shopping with her daughter and each could tell without speaking when the other would like a certain item of clothing. This was clearly not a psychotic response, as was apparent from the followup interview. This same patient had answered a large number of items in the pathological direction, but upon questioning, each item was found to be explainable in a manner similar to that above.

The followup interview is often the beginning of insight into an illness and its ramifications. Often, the EWI is the first brush a patient has had with an open discussion of the perceptual anomalies he/she has experienced, and many patients have expressed gratitude that someone has finally discussed with them experiences which have been so real but previously un-recognized by treatment people. This interview technique goes a long way toward establishing rapport with a patient, as he or she and the therapist are speaking the same

TABLE I SPECIAL EWI SYMPTOM CHECKLIST

Depression Items

1. I am afraid of the future.
2. It is too late to try to be somebody.
3. I turned out to be a different kind of person from what I wanted to be.
4. I have little respect for myself.
5. I hate myself.
6. I wonder why people are so grim.
7. People act as if I were not there.
8. I cannot make sense of what I read now.
9. I have difficulty getting to sleep.
10. I am a failure.
11. I have become an awful burden to my family.

Illness Items

12. Days and nights are all alike to me.
13. Quick movements frighten me now.
14. Sunlight seems dazzling.
15. Straight edges such as those of walls and floors look curved at times.
16. Everything seems to have slowed down.
17. People's talk is becoming unclear to me.
18. Voices of people sound sharp and harsh.
19. My skin is very sensitive.
20. I sometimes leave my body.
21. I have new ideas about religion and the world entirely different from anything I have ever thought before.
22. I seem to have discovered the secrets of the universe.

language — experiences, rather than the interpretive jargon of traditional evaluative instruments and methods. The interview often provides the initial steps to the therapy process, as the EWI items provide a common base upon which the therapist and the patient can begin to discuss the illness. In some cases, also, the items are similar to experiences the patient has had but not identical to these experiences. In the interview, the patient can bring out these differences and the therapist can gain a fuller understanding of the patient's experiential world.

It is frequently the case that a patient is unable to participate in the usual evaluation process due to illiteracy, poor attention span, confusion, or unwillingness to work alone on tests. In such instances, we have used the followup interview procedure as an evaluative mechanism. The patient is asked about various perceptual anomalies as well as demographic and historical data, medical history,- and mental status information. From such an interview, enough information can usually be obtained, at a pace comfortable to the patient, to make a diagnosis and to map out

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TABLE II

SPECIAL EWI SYMPTOM CHECKSHEET

Directions: Each day, at the same time of day, read each item and gheck the box if you have had that experience that day. Count the number of checks for your daily score.

ITEM DAYS:

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10																						
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TOTAL																						

the patient's experiential world. Most patients find this kind of interview more meaningful than the traditional mental status and history alone, and valuable information can be gained for the clinician by the addition of the EWI questions to the usual interview.

Treatment Monitoring

One of the most crucial and sometimes difficult tasks of the clinician is to evaluate the effectiveness of treatment methods and to make necessary changes in as timely a fashion as possible. The EWI lends itself to this use through development of specialized symptom checklists and experiential/behavioral scales, which can be used by patient, family, or treatment staff in a hospital or other facility.

For use in individual treatment monitoring by the patient, we construct a special symptom checklist. An example of such a checklist is shown in Table I. We begin by administering the EWI to the patient, conducting an interview discussing the items answered in the pathological direction, and condensing these items into a critical item list which can be used to monitor the patient's progress and response to various treatment methods. In interview, we attempt to discover which items are most critical in the patient's view; that is, those items which the patient states occur with regularity during his/her illness. We then give the patient a list of these items, which often contains experiences which occur during extreme illness as well as experiences which serve as forewarnings of an approaching relapse. The patient then uses this list to monitor his/her condition on a daily basis, by checking daily the items which were experienced on a checklist such as that shown in Table II. The patient is thus a vital participant in his/her own treatment and becomes invested in its success. In this way patient responsibility is fostered and the patient's information is used in making treatment decisions.

An example of the use of this method is that of a patient who suffered from a cyclic psychotic illness, probably schizophrenia.
The tables are derived from her case history. Through interview following administration of the EWI, we discovered that she experienced extreme perceptual distortions during periods in which she was psychotic, but that prior to each psychotic episode, she experienced a depression or dysphoria which was exemplified by the items on the upper part of the symptom checklist. Using this list enabled her to be forewarned of an approaching psychotic episode and to take steps to get immediate treatment or to control her stress level, since in her case her psychotic episodes seemed to be related to periods of intense stress. In this way she was able to decrease the severity of her psychotic episodes, through early recognition of an approaching cycle and the application of stress management methods.

While some patients are able to detect illness through subjective observation or body-awareness, we have found that many patients need an objective measure of symptoms, and the specialized EWI symptom checklist provides such a measure. The patient can, at the same time each day, review the symptom list, checking off those experiences which have occurred during the day, and determine a course of action from the number of experiences checked.

In cases where the patient is unable to carry out the monitoring procedure independently, the family or staff responsible for the patient's treatment can use the experiential/behavioral scales we have developed for treatment monitoring. This method is an extension of the symptom checklist, and involves the matching of behaviors with experiences to develop an experiential/behavioral scale. The technique was pioneered with a single patient in a family living situation (Osmond, Mullaly, Bisbee, and Bisbee, 1978), and was further applied with large groups of patients at Bryce Hospital by Dr. Paul Bisbee and colleagues (Bisbee and Houston, 1978). The technique involves the development of a symptom checklist as described above, and the matching of behaviors which usually occur with each experience. The patient is first given the EWI and a specialized

TABLE III

Experiences		
1. I am constantly in a hurry.	1. Hurried, speeded up, hyperactive, wandering, pacing.	1.
2. Quick movements frighten me.	2. Startled response, jerky movements.	2.
3. Memory has gotten worse.	3. Unable to recall recent events, remember to do things.	3.
4. Thoughts crowd into mind too fast.	4. Rambling, irrational talk, shifting topics, losing train.	4.
5. Cannot think in concentrated way.	5. Short attention span, unable to make simple decisions.	5.
6. Strange ideas come into head.	6. Bizarre talk, inappropriate laughter.	6.
7. Difficulty getting to sleep.	7. Late bedtime, up during night, sleepless nights.	7.
8. Joints loosening up.	8. Stiffness, shakiness, gait stiff, strange, uncoordinated.	8.
9. Periods where nothing diverts attention.	9. Rearranging objects.	9.
10. Everyone seems to have changed.	10. Forgetting and mixing familiar names.	10.
11. People's talk is unclear.	11. Unable to answer questions.	11.
12. Anger.	12. Verbal or physical hostility.	12.
13. Straight edges seem curved at times.	13. Misjudging distance going around corners and on stairs.	13.
14. Objects seem to be too close.	14. Takes long steps away from people or steps up too closely.	14.
15. Must always be on guard.	15. Secretive behavior, eavesdropping on conversations.	15.
16. I loathe people who touch me.	16. Avoiding contact.	16.
17. I know things others do not know.	17. Arrogant and informative.	17.
18. Constant talking.	18. Chanting, repeating same sentence over and over.	18.
19. Terrors of hell approach.	19. Clinging and staying close to familiar people.	19.
20. I am not in full control of self.	20. Unable to help self, letting others do everything for her.	20.
21. I hate myself.	21. Asking for forgiveness, punishing self.	21.
22. I am a failure.	22. Saying she is failing, not doing right thing.	22.
23. My reflection in mirror looks strange.	23. Posturing, over-interest in mirror.	23.

EXPERIENTIAUBEHAVIORAL SCALE

This is a worksheet for daily data collection. Variations in scores reflect illness cycles and can be used for monitoring of treatment.

Staff observe behavior and check its presence each day.

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symptom list established through interview. Then the staff who work with the patient map out what behavior is likely to be associated with each experience, and these behaviors are validated by getting the patient's agreement. Once a behavior is associated with each experience, the experiences have by inference become open to observation by staff members and the treatment monitoring can be done by these persons. With this system, the effects of treatment on experience as well as on behavior can be determined.

An example of this phenomenon is that of our single patient in the family living situation, whose experiential/behavioral scale is found in Table III. It was discovered through interview with the patient, for example, that a very common experience she has during her psychotic episodes is exemplified by the EWI item, "My joints are loosening up." When the patient is experiencing this phenomenon she walks with a strange gait which the staff have described as a "crab walk." When she is having this experience, it seems to give her more confidence to walk very slowly with her face near the floor and to place her feet very carefully. Thus the staff can determine when she is having this experience through observation of her behavior. The same is true of the other items on the scale.

At Bryce Hospital, Dr. Paul Bisbee used much the same method with a ward of chronic schizophrenic patients who were unable to do their own treatment monitoring. He matched their EWI experiences with their performance on the Missouri Inpatient Behavior Scale (MIBS), a staff administered ward behavior inventory (Hedlund, 1973). Thus treatment monitoring could be carried out by the staff through observation of the patients' behavior. This method is helpful also to the patient in that he/she can learn to associate certain experiences with particular behaviors and thus gain insight into the antecedents of these behaviors. In many cases such behaviors as self-mutilation, aggression, or destruction of property can be prevented through warning by the associated experience. The staff also learn to associate the behaviors with the fact that the patient is experiencing perceptual distortions, and aim treatment intervention toward helping the patient deal with the experience through stress management techniques or other methods. This approach gives much more information and is much more comforting to the patient than a strictly behavioral interpretation of the patient's actions and treating of the inappropriate behaviors with behavioral programs only. The experiential/behavioral approach is more complete and more effective as well, and takes the patient's view into account.

The experiential/behavioral approach to treatment monitoring has been shown to be very effective with patients in a variety of settings, including a private home, a state mental institution, and a private psychiatric facility, and we have begun to extend the technology to the community mental health setting through a developing residential treatment facility. The goal of all treatment monitoring systems is to improve treatment by enabling the patient and those working with him or her to predict and prevent episodes, and to reduce the impact of the unexpected "relapse" or "breakdown." The experiential/behavioral system we have described has this ability to predict episodes, to allow for timely interventions, and to evaluate the interventions applied.

Patient Education

Another area in which we have developed the EWI as a valuable tool is that of patient education. We have carried out patient education both with individual patients and with entire classes of patients enrolled in our patient education • programs at Bryce Hospital (Bisbee, 1979) and at St. Albans Hospital. The EWI provides us and the patients a common language to discuss mental illness, and we use the items daily in our classes and individual sessions. They provide excellent examples for use as illustrations of various points we are making in the teaching of patients about mental illness, and the patients identify with the experiences. We use the EWI items as springboards for discussions of the bio-

chemical basis for perceptual changes, and for providing alternative explanations to replace the "delusions" patients have built up to explain the perceptual anomalies they have experienced.

In our classes, our goal is to induct the patient into the sick role, by explaining the biochemical basis of mental illness. We have in our classes patients who have been told that their illnesses are the result of "bad mothering," a "search for enlightenment," or the manifestation of being "crazy." We attempt to explain to the patient that the experiences he or she is having arise out of a biochemical imbalance rather than from these other sources and that there is hope for getting better through medical and psychological treatment. The EWI is particularly useful with our schizophrenic patients and those with mood disorders. Many of the items on the EWI are the perceptual distortions which commonly occur in schizophrenia, such as distortions of sensory perceptions in all spheres, including vision, hearing, taste, smell, touch, body position, and time. These experiences are openly discussed in patient education classes as symptoms of a biochemical disturbance. Patients are taught to understand this explanation of their symptoms and are given the opportunity to accept this explanation in place of the "delusions" they have developed through attempts to find explanations for their perceptual distortions. For the classes on mood disturbances we use the EWI items having to do with overstimulation and elation, and those concerning dysphoria or depression. The EWI is a very useful device for the patient education classes because it gives the patients the reassurance that those who are teaching do have some idea of the frightening perceptual disturbances they are experiencing, as well as a plausible and less frightening explanation for these experiences.

Individual and Family Psychotherapy

We have found the EWI to be extremely useful in psychotherapy with patients and their families. In psychotherapy with individuals, the EWI is useful from the initial interview through the course of the therapy sessions and as a maintenance instrument the patient can use after therapy is terminated. Through examination in therapy of each item answered in the pathological direction, the patient begins to gain insight into the stresses in his or her life which contribute to a worsening of the illness, and in therapy we can then proceed toward helping the patient to learn stress management techniques and to solve the problems of living which cause undue stress. In this way, we break down the barriers to successful symptom control and provide the patient a means of being responsible about illness.

The EWI can also be used in family therapy, as a source of helping the patient's family understand the experiential world of the patient. We have used a technique where we ask the family members to take the EWI as if they were the patient. The resulting comparison of the patient's symptom list and the list produced by the family of experiences they believe the patient to be having is usually quite enlightening. We have often found the situation where the family of a patient will believe the patient is depressed, as judged by the patient's quietness and withdrawal at home, whereas in actuality the patient is suffering from schizophrenia. The patient has withdrawn, not due to depression, but because his/her perceptual world is "going to bits" and withdrawal is less painful than dealing constantly with perceptual distortions. This kind of information is extremely valuable to the family in understanding the patient, and it is most clearly given to the family in the form of actual experiences of the patient rather than through another kind of explanation a professional might give to them about the nature of schizophrenia in professional jargon. The EWI has become an invaluable aid to understanding between patient and family and to treatment of the patient at home through the patient's and family's use of the specialized EWI symptom checklist.

Case Example

The curious story of Mrs. X. serves as an

example of the EWI as a diagnostic and therapeutic tool. Mrs. X. is a married lady in her early 40's who was seen by Dr. Humphry Osmond in Bryce Hospital. She came into the hospital at the insistence of her mother, who calls herself a health food nut. Mrs. X. had made a serious suicide attempt, one of a series which have endangered her life during the last 16 years or so. She was given the EWI by Dr. Paul Bisbee after her admission.

Mrs. X.'s illness, which has caused her to spend many months in hospital has usually been called a "depression." She herself has worked in a mental health center and has never agreed with this view of her condition. She is very introverted and a feeling person, and although she has not agreed with her doctors she has been reluctant to correct them, due to the fear that she would not be believed.

The EWI showed that she had a great many perceptual disturbances in every sensory modality, and she was also very depressed. This depression was hardly surprising because she has been haunted by a terrifying vision, which is a sign to her that she is going mad. She described looking out of a hospital window and seeing a great pit, with creatures which she describes as gargoyles flying around its edges. She knows that such things do not exist, but they are there. She becomes increasingly frightened as the pit and its inhabitants become more and more vivid.

At an interview, Dr. Osmond discussed with her the genesis of her perceptual disturbances. She seemed relieved to talk about these matters in a common sense way. She was pleased to be given a plausible explanation backed by medical authority for her distressing perceptual experiences.

As can be seen from this example, the EWI was valuable in making a diagnosis and in teaching the patient about her illness in individual therapy, specifically in eroding delusions and replacing them with medical explanations, and in moving the patient into the sick role. In this process, the therapist presents the patient with hypotheses about her illness based on the EWI and on her own reports, and asks her if these hypotheses
make sense to her. The therapist and patient are thus engaged in a cooperative activity, in which the patient participates freely and willingly. This technique can be developed and taught to others much more quickly than comparable psychotherapeutic techniques. It has the great advantage that it can be checked with the patient's experience at every step and that every check emphasizes and rewards the patient's participation as a responsible patient (Osmond, 1979).

Conclusions

The uses of the EWI appear to be almost boundless when one considers both the traditional use of the EWI as an accurate, reliable, and valid diagnostic test, and the expanded uses outlined in this paper. The use of the individual items is limited only to the imagination of the clinician. We have had success with the EWI as an interview tool, both with patients who are unable to be evaluated by the usual diagnostic methods and as a followup method designed to get the maximum information out of the diagnostic evaluation. We have used the items to construct experiential behavioral scales for treatment monitoring and evaluation of interventions. We have found the EWI useful in patient education classes, and in individual and family psychotherapy. These expanded uses of this valuable test are only the beginning of an important technology for therapy with patients who have been thought to be very difficult to treat with any methods other than medicine, and further developments can only serve to improve the technical skills of clinicians and the hopes of patients.

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