subjective experience of schizophrenia*

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For those of us who have not become psychotic ourselves, the subjective experience of psychosis is not readily comprehensible. For the most part, the experience of an acute schizophrenic psychosis is inferred from behavioral observations. Articulate patients have verbalized the experience in some instances; even more rarely, understanding has been enriched through such sensitive accounts as *I Never Promised You a Rose Garden* (Green 1964) and *The Bell Jar* (Plath 1971). We take verbalization so for granted as the primary mode of communication that we sometimes overlook other possibilities. One such possibility is patients' drawings.

Although there has been an interest in the art of schizophrenics for many years, we know of no other systematic attempts to gather data that would tap into the subjective experience of the psychotic process through art expression.

Method

In order to view the acute schizophrenic episode through the patient's eyes, we requested that patients draw a picture of their psychiatric illness in drug-free periods during the acute phase of illness, at recovery, and at 1-year followup. The results of this specific request differentiate our study most significantly from other reports. During a 3-year period, 56 acute schizophrenic patients were evaluated. Of these, all participated in an admission art evaluation session, 49 in a discharge session, and 42 in a followup session. Patients were hospitalized on a 12-bed research ward at the National Institutes of Health Clinical Center in Bethesda, Md. Maximum hospitalization was 4½ months.

Patients admitted to the study were diagnosed schizophrenic by referring and screening clinicians. Patients with a history of manic-depressive illness were excluded. An extensive clinical evaluation was accomplished during an initial 3-week drug-free period, and final diagnosis was based on all available information using DSM II (American Psychiatric Association 1968) categories and criteria. Only patients diagnosed schizophrenic were included in the study. This diagnostic assignment was supported by applying two additional sets of criteria. First, the patient cohort averaged 6.2 points on a 12-point flexible system for identifying schizophrenic patients, a level highly associated with a schizophrenic diagnosis (Carpenter, Strauss, and Bartko 1973). Second, a profile analysis of variance comparing this patient cohort with the patient cohort diagnosed schizophrenic in the International Pilot Study of Schizophrenia (World Health Organization 1973) revealed no difference in either pattern or level of psychopathology. This comparison is based on 27 sign and symptom dimensions reflecting current mental status as measured by the Present State Examination (World Health Organization 1973). Admission criteria for this program specified relative adequacy in social and work functioning prior to the present psychotic episode, thus assuring an acute and subacute schizophrenic population. Based on Phillips Scale ratings (Garmezy 1965 and Phillips 1953), two-thirds of these patients were classified reactive and one-third process. The average age was 23.607 ± 7.36 years; the patients came predominantly from social classes II, III, and IV; and there were 29 females and 27 males.

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The Art Therapy Sessions

All patients participated in individual art therapy sessions during drug-free periods as stated and were requested to draw the following pictures in the same sequence at each session:

- Free picture—that is, no assignment
- Self-portrait
- Picture of their psychiatric illness
- Hallucinations experienced
- Delusions experienced

Following the execution of each picture, the patients were encouraged to discuss it. The patients' verbal explanations and free associations provided abundant data so that interpretations and speculations have been minimal. All sessions were tape recorded, providing us with records of the patients' comments, as well as the art productions themselves.

The information for this report comes from the picture of the illness task. Content of the psychosis has been especially forthcoming from patients drawing their hallucinations and delusions. This material has been reported elsewhere (Wadeson and Carpenter 1973 and 1974).

Results

The following results reflect the meanings these pictures held for the patients. They conceptualized in graphic terms their experience of the illness, discussed the intended significance of its various aspects, and, in some instances, proceeded to free associate to the picture illuminating the ideas represented. We have organized the material into the following categories:

- Feeling states
- Depiction of brains
- Representations of physical illness
- Locus of illness

Feeling States

Depression

Most prevalent were designations of depressed feelings (52 out of 56 patients). Sometimes a person was drawn and described as having a depressed expression. In other instances patients drew tears, rain, and clouds that they said expressed depression. Often, depressed feelings as designated by the patient were represented by gray, black, or blue colors. In addition to the picture of the illness, such representations appeared in other pictures as well, particularly self-portraits.

Figure 1 is a picture of the illness in which a young man has drawn himself in the center: "a creature, a blob, everything is gray." His associations were frustration, represented by blue; depression by yellow; and suicidal tendencies by gray. He elaborated the last association further, saying he felt "trapped, closed-in, worthless, and suicidal." The spiral form is very characteristic of depression and is often associated with suicide (Wadeson 1971).

Although depression has been observed in the behavior of many acute schizophrenics following the psychotic episode, these expressions of depression occurred as frequently during the admission session (acute phase) as at other sessions.

Confusion

The experience of confusion was expressed graphically by 28 out of 56 patients in their pictures of the illness. In a few instances, the pictures themselves were extremely confused and disorganized. Although the patients were usually more confused at the admission session, such representations did not occur in their pictures more often at that time. This finding is not surprising when one considers that in drawing a picture of the illness at discharge and followup, the patient was often recollecting a period of confusion experienced earlier.

These representations were often characterized by tangled lines and colors or people whose facial expressions looked confused to the patient. Figure 2 is a confused picture of the illness, whereas figure 3 is a picture of confusion in which the patient has represented his brain as being ordered before the illness (top), confused during the illness (middle), and reordered at discharge (bottom).

Anger

Anger was represented in 23 of the pictures of illness. It took the form of associations to the picture more often than direct expression in an image. Often the anger was directed toward staff members and friends or family for placing the patient in the hospital.

Figure 1. Depression.

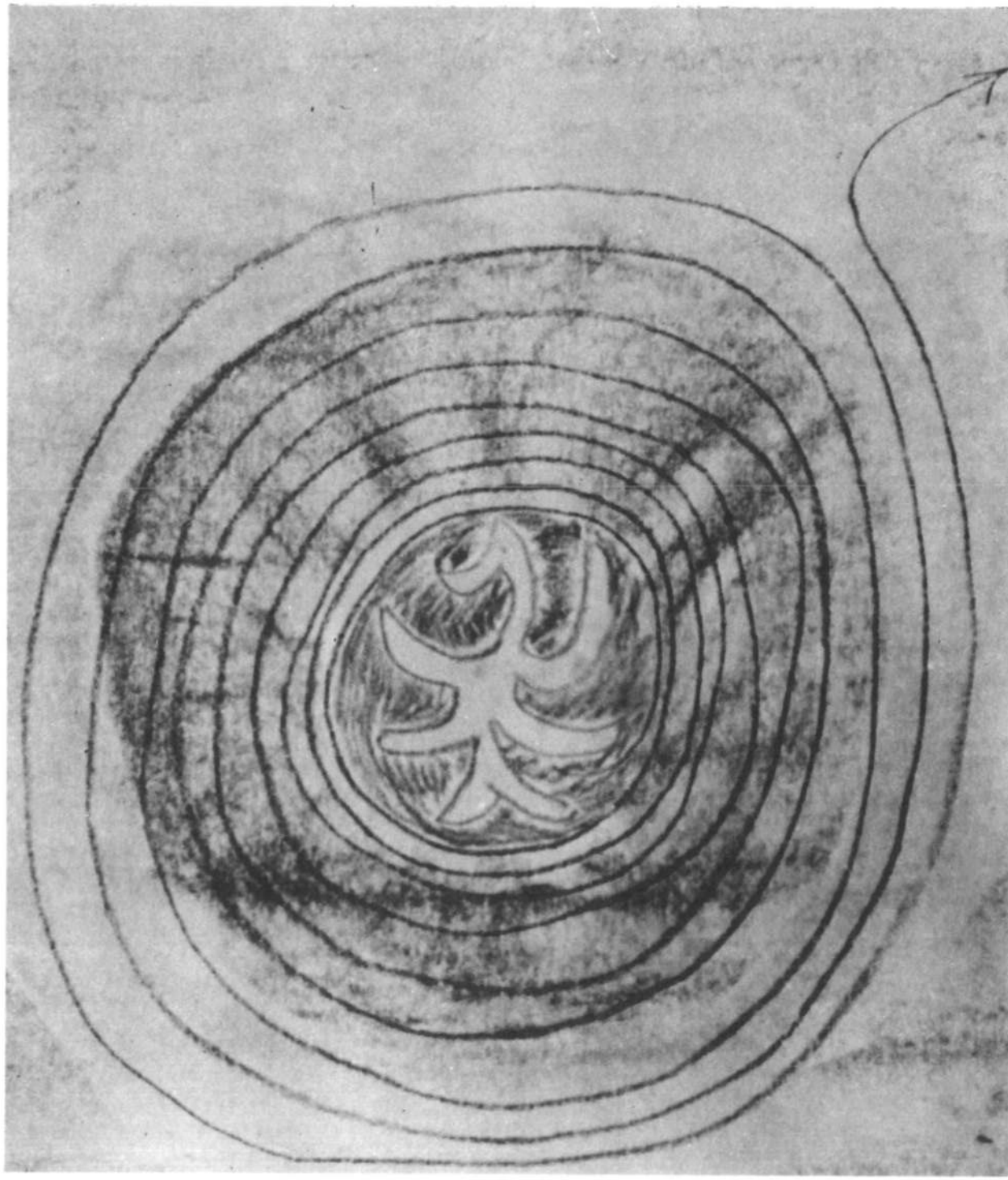


Figure 2. Confused picture of illness and euphoric feeling of "acceleration of talent."

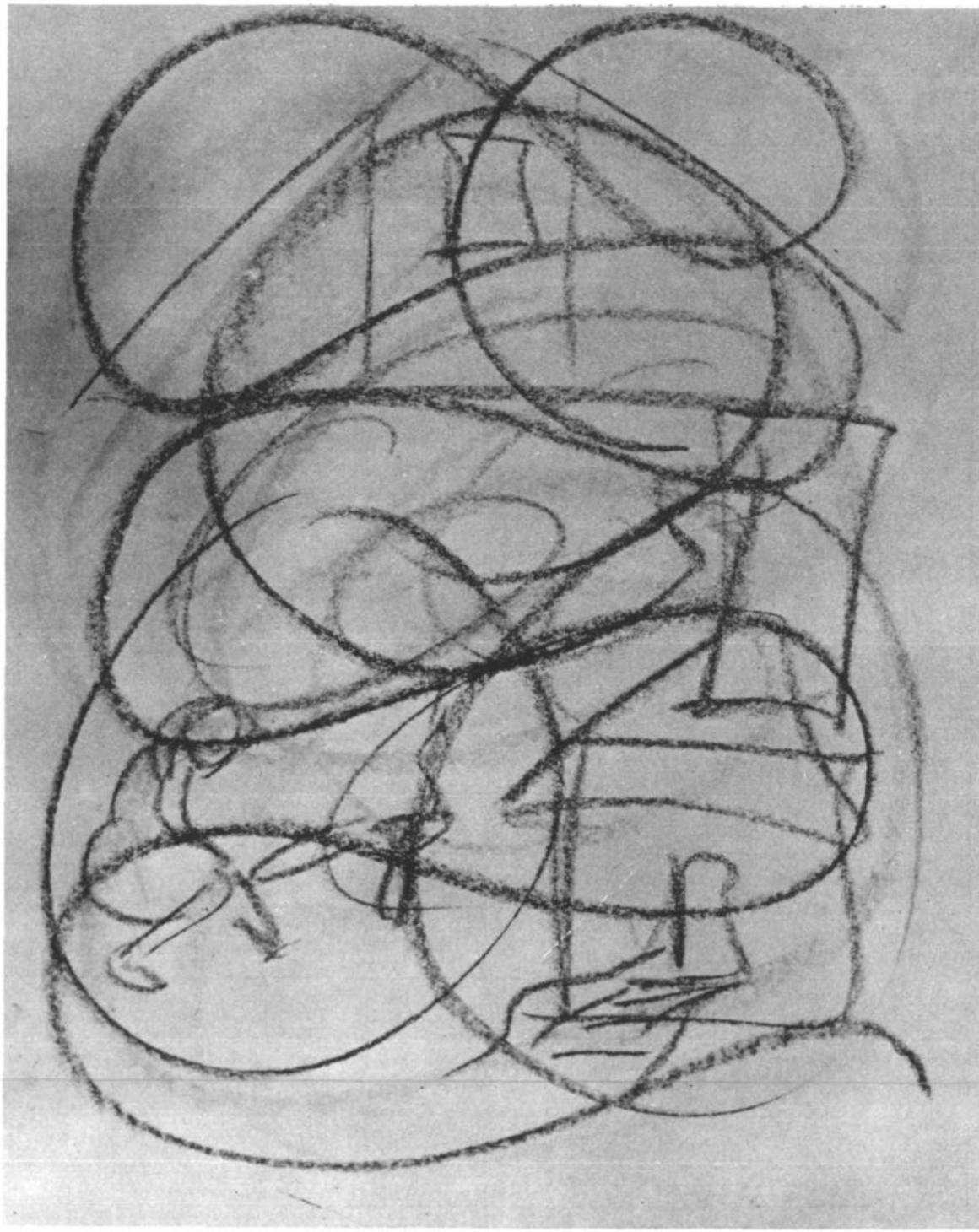


Figure 3. Brain depicted as ordered before illness (top), confused during illness (middle), reordered at discharge (bottom).

As a young man was drawing figure 4 at his admission session, he asked if he was making the art therapist uncomfortable because he was expressing his anger on paper and could not communicate with his "idiot psychiatrist." His anger was connected with associations to his father who had abandoned him. He then said that the spirit of the picture was "hate" but amended it to "resentment," saying that one cannot really hate, and "only a crazy person would be glad to see another harmed."

Positive Experience of the Illness

In the context of the experiences of depression, confusion, anger, and physical illness, particularly impressive were the positive aspects of the psychosis for some of our patients: 11 indicated so specifically. For some, the illness was a rest or respite from life with an appreciation of hospitalization as a means of separation from the turmoil of family life. For others, there was a maniclike euphoria described as feeling happy, high, or being full of energy, enthusiasm, and talent. In her most disorganized picture (figure 2), one patient expressed her experience of her illness in lots of motion and color. She said she was not ill but had "an acceleration of talent." She had used her favorite color combination in the picture, which she called "lively and festive." In addition to such direct statements, there were many examples of grandiosity that provided obvious gratifications. In figure 5, a young man drew himself as a witch doctor who could control others. This picture was drawn at 1-year followup, at which time the patient felt depressed. He said he longed to become crazy again, finding himself more interesting to himself and others when psychotic.

Depiction of Brains

Since the task of drawing the psychiatric illness is a vague, relatively nonspecific assignment, we were most impressed with the repeated representation of a specific object to symbolize the psychosis. Fifteen of the 56 patients drew their brains, indicating pictorially and verbally that something was wrong with them.

When requested to make a picture of his illness at discharge, a young man drew his brain (figure 6), saying it went "foggy" as indicated by the black. The lightning bolts represented confusion instead of the normal

Figure 4. Anger and hate.

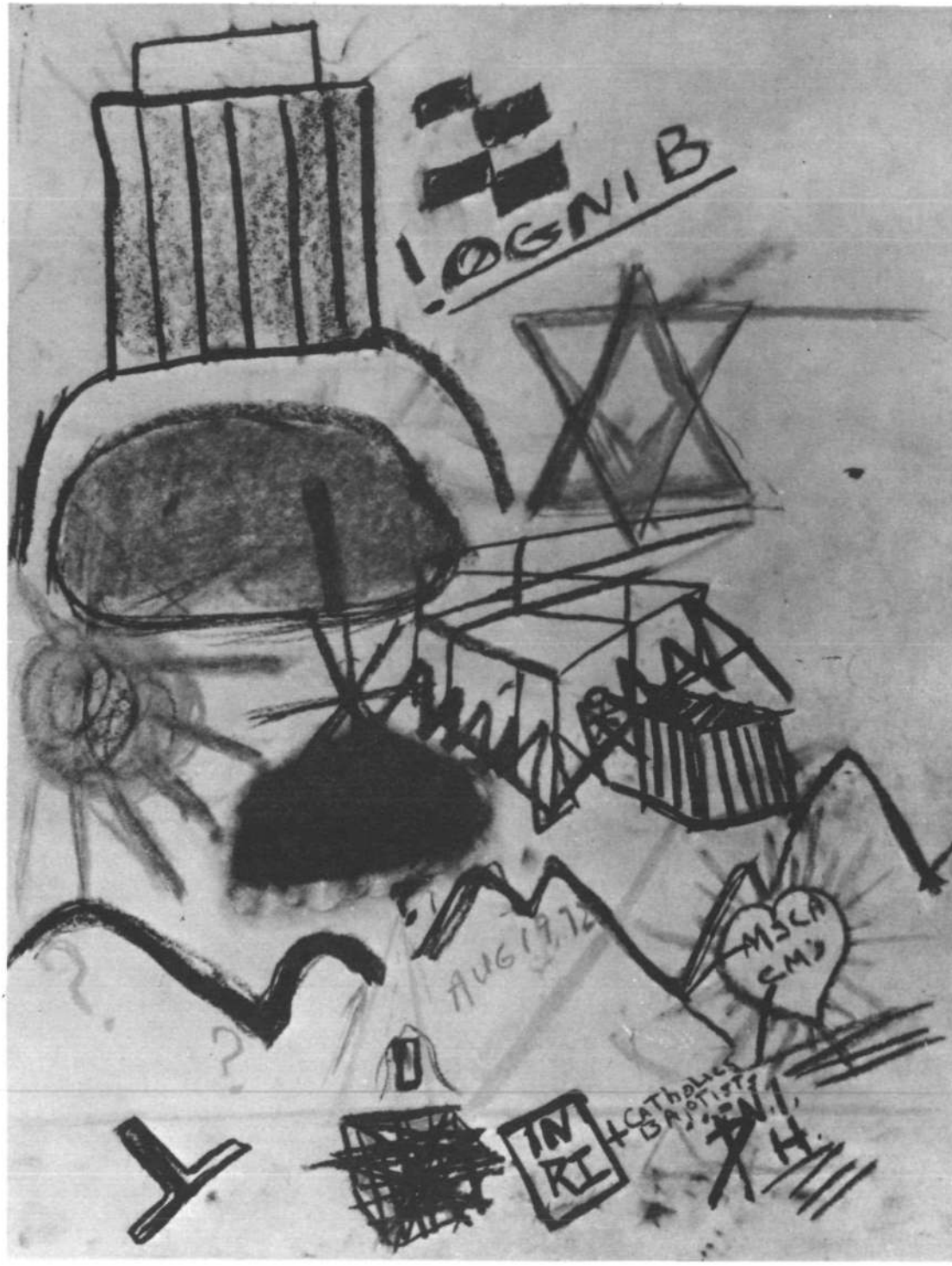


Figure 5. Wish for return of psychosis in which patient believed himself a witch doctor.

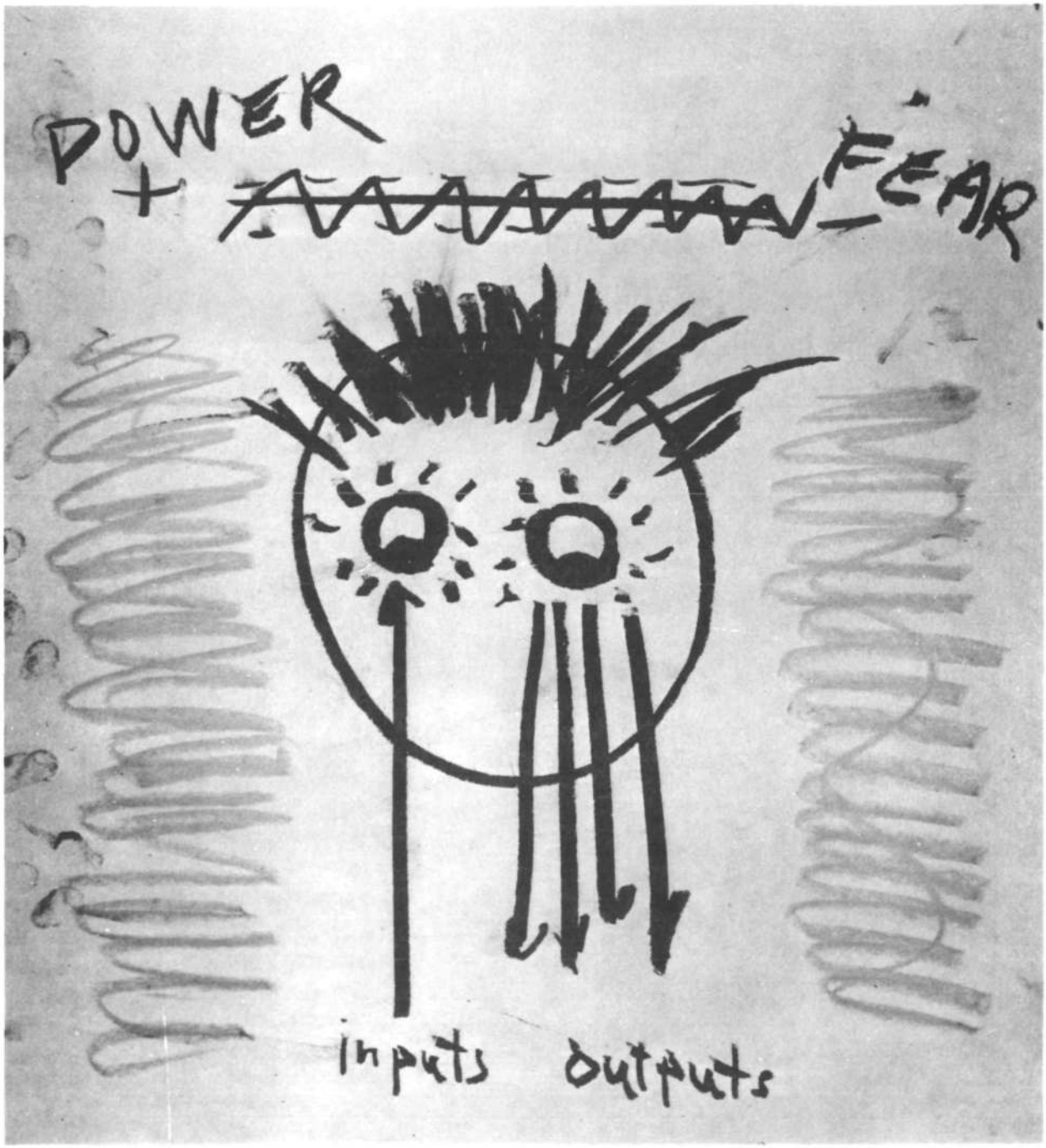
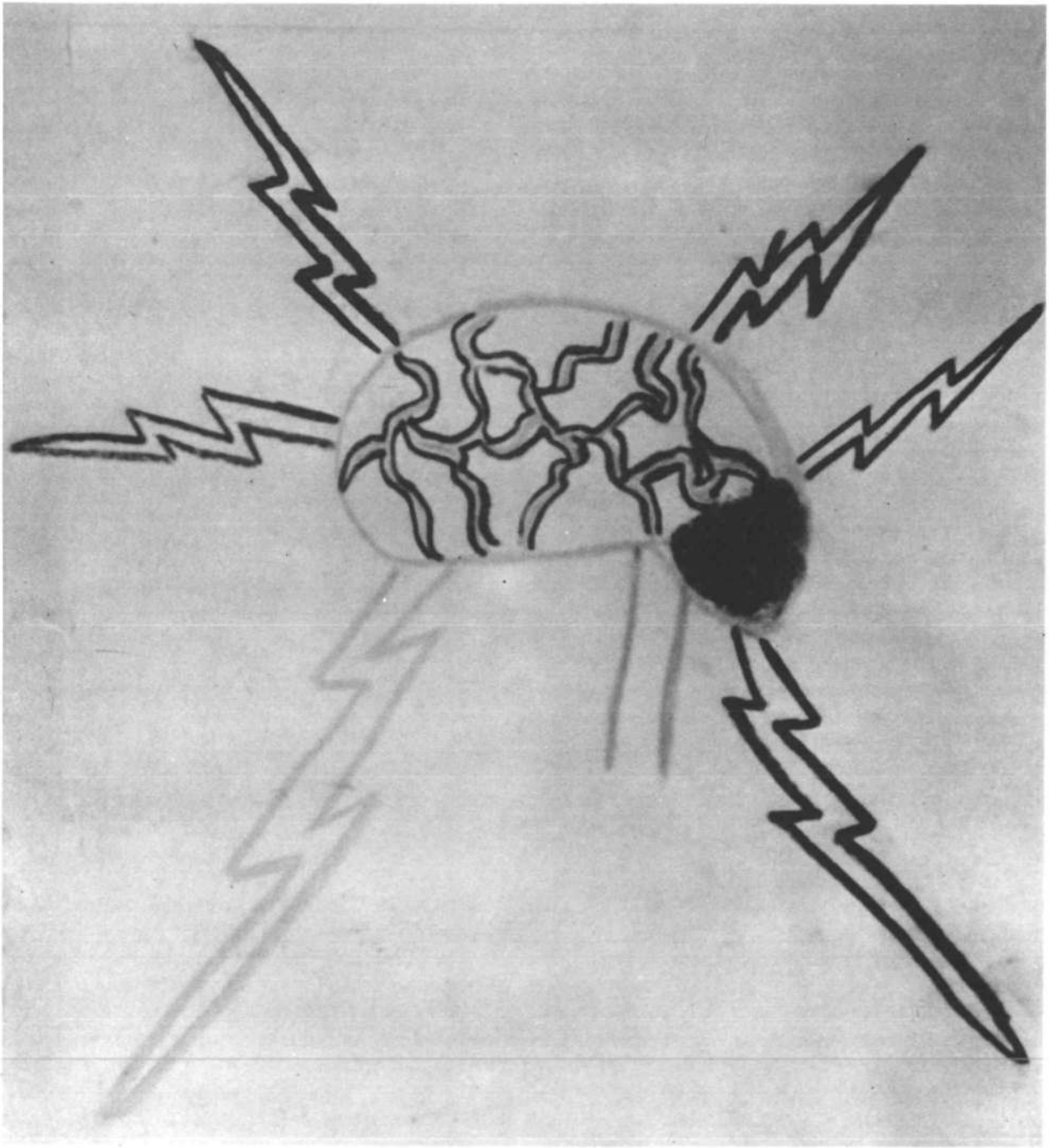


Figure 6. "Confused, foggy" brain.



sending of messages, which he said were warnings and cries for help.

Physical Illness

Twelve patients believed they were physically ill or impaired. In some cases, patients thought they were suffering from specific diseases, such as cancer (most frequent) and heart disease. In a number of instances, the concerns were more idiosyncratic, such as the belief by one patient that her corneas had fallen off.

In figure 7, a patient drew her illness in a representation of herself with a sore back she hurt in an automobile accident. At this time, she was delusionally worried about becoming a hunchback. Her expression here was gloomy, whereas her self-portrait drawn just before this picture depicted her standing up and looking cheerful.

Locus of Illness

The pictures often provided information about patients' experiences of the locus of their illness. Although there were contradictions as well as sessions when such information was not forthcoming, in most instances it was possible to determine from the pictures whether the patient believed 1) he was not ill, 2) the illness was related to external forces, 3) the illness was internal and biological, 4) the illness was internal and psychological, or 5) some combination of the above. There were more than twice as many pictures indicating an internal psychological locus than any other. Next in incidence was an external locus. Figures 8, 9, and 10 illustrate a shift in locus.

A young woman made similar pictures of her illness at each session, but with a somewhat different view each time. At admission she depicted herself blasted by a drug experience in which she believed she was strangling and being gassed (figure 8). She was being assaulted by an outside agent, LSD, drawn in purple around her. At discharge a similar configuration appeared with her physical self no longer an element in the picture (figure 9). She was represented by the "weak blue circle" in the center bombarded by external forces drawn in red representing drugs, boyfriend, and sister. The prominent self of the former picture had disappeared and the focus was exclusively on the external agents.

Figure 7. Delusion of becoming a hunchback.

At 1-year followup, she drew her physical self again looking "helpless, out-of-it, spaced-out" (figure 10). Once again the bombardment was red. It represented "forces . . . interfering with my being able to perceive reality . . . something that my mind created." The powerful forces she had found so frightening were perceived at followup as part of her own mind. Although the self had been drawn prominently initially (figure 8), the illness was not then integrated as a part of the self. At followup, however (figure 10), an integration was achieved. This picture appeared to be a synthesis of

Figure 8. Being blasted by LSD experience, admission.

Figure 9. Being bombarded by drugs, boyfriend, and sister, discharge.

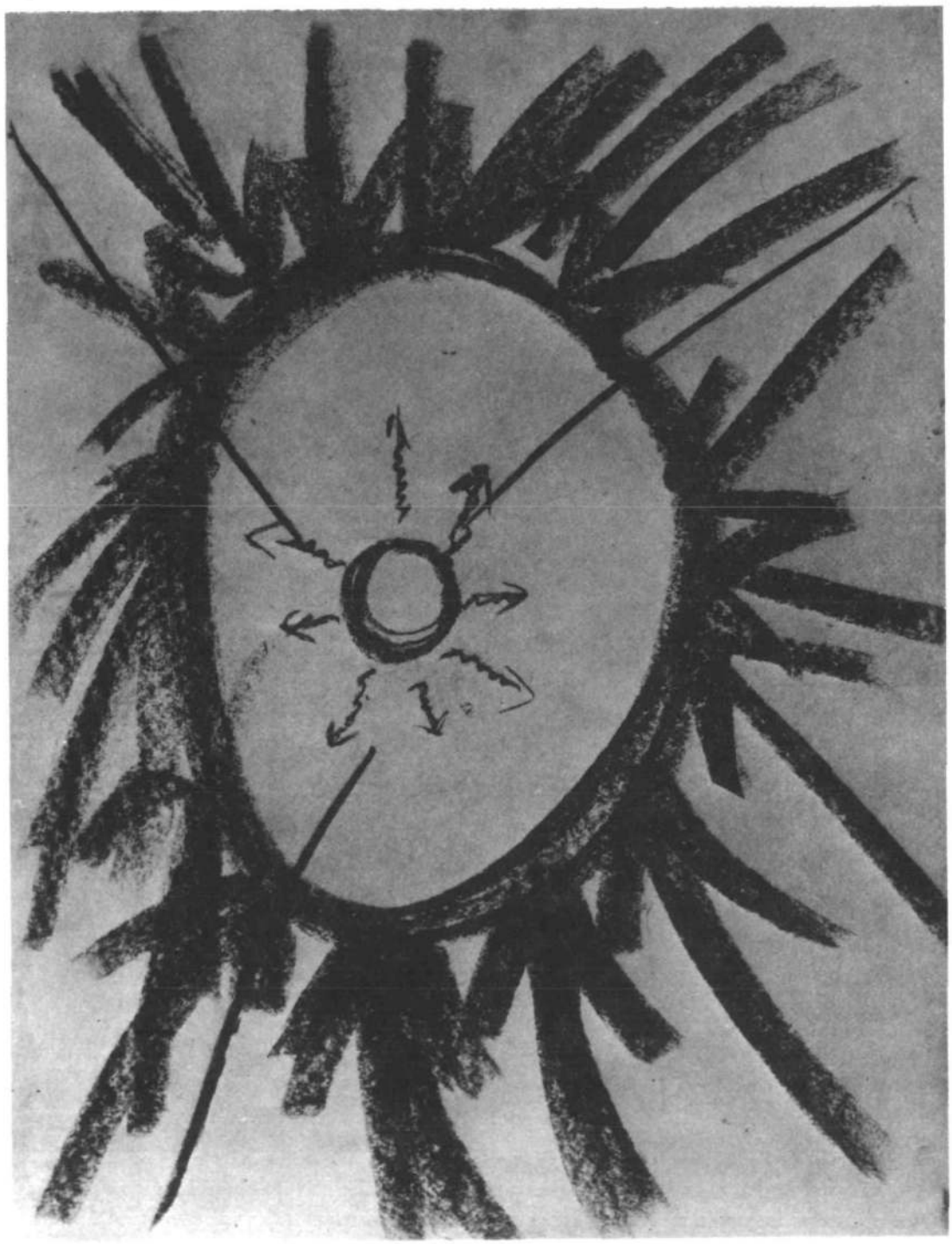


Figure 10. Forces created by her own mind, followup.

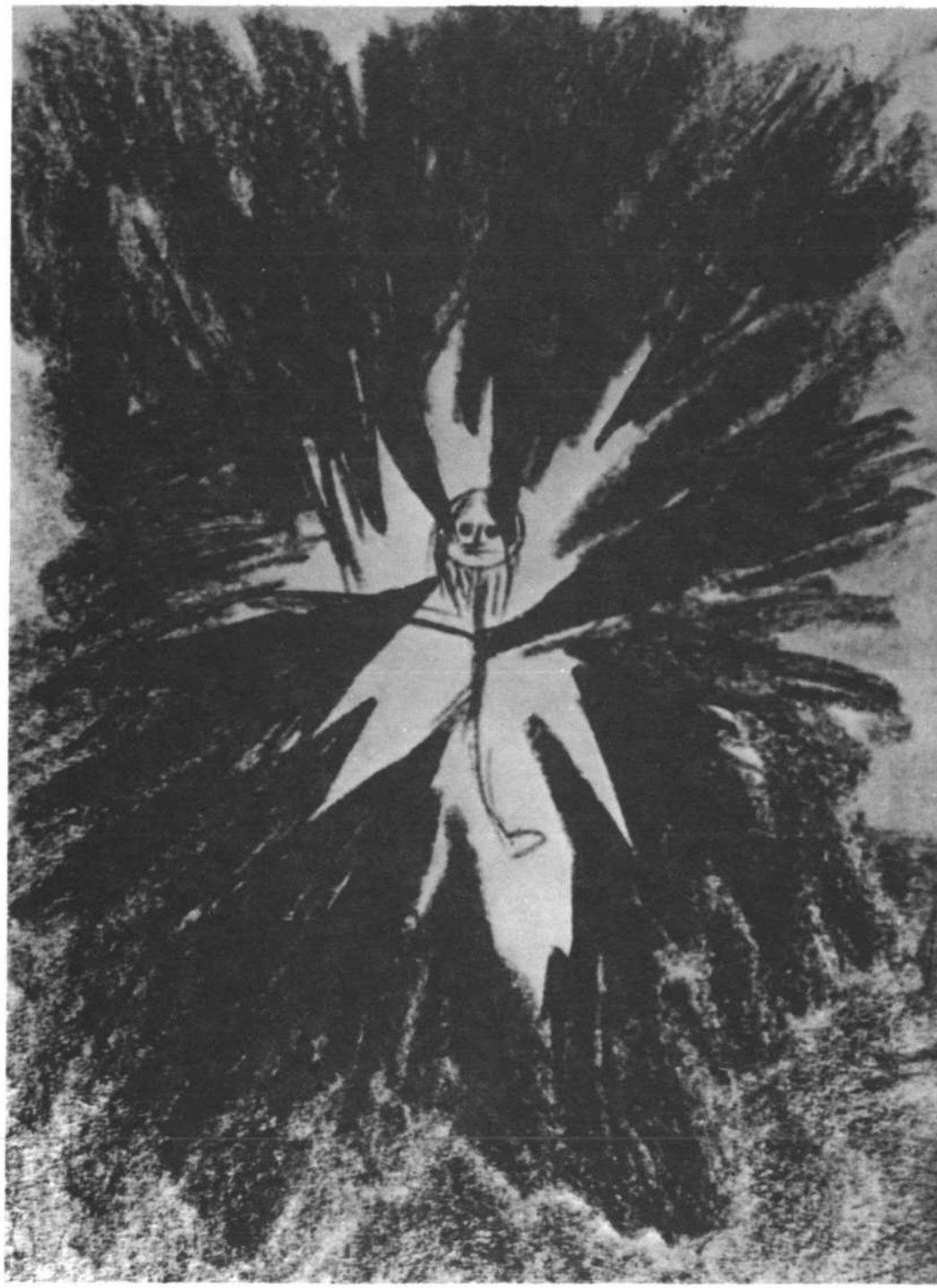
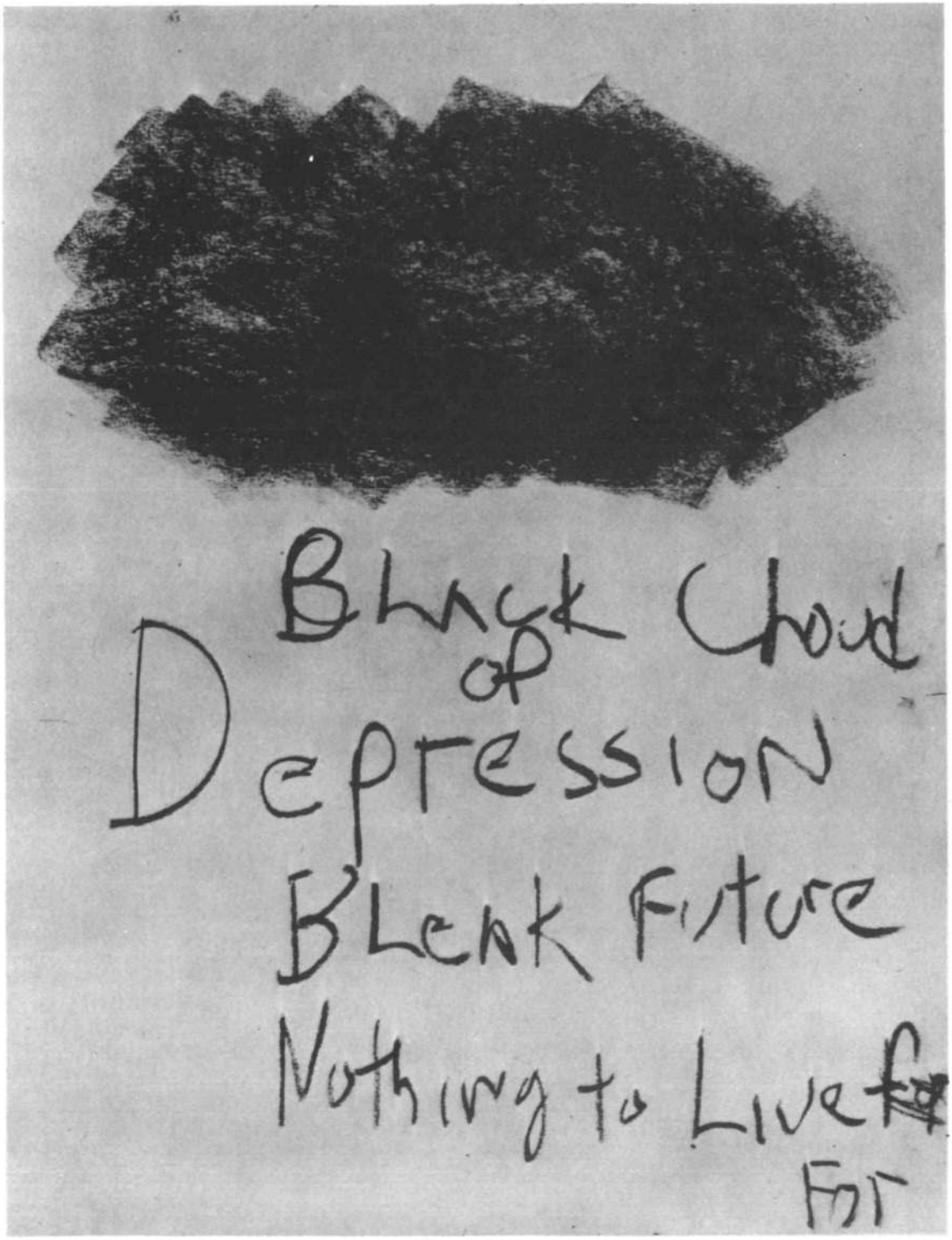


Figure 11. Depression.



earlier elements: her helpless self and a powerful representation of the devastating forces that she recognized at followup as part of herself. The biological factor of drug influence disappeared altogether.

Discussion

The request to make a picture provides the patient a *tabula rasa* on which to project his choice of a view of his inner experience. It is this selection process that highlights the meaningfulness of the picture's content. Pictorial style adds a further dimension, often less conscious and more a reflection of a patterned response or present state of feeling. These two factors, selection of content and patterned or affectually determined style, lead us to regard the art material as a particularly significant expression of subjective experience. Therefore, in requesting patients to draw their experience of the psychosis, we believe we maximized an opportunity to view what was most significant and had the greatest impact on the patient. We know of no other instances where patients have been requested to perform this specific task. Nevertheless, not surprisingly, many of the elements expressed in the picture of the illness appeared in other pictures as well, although usually not so pointedly or pervasively.

Some of the material conformed to generally held impressions of schizophrenic experience. In regard to feeling states, confusion and anger are expected reactions. Somatization in a delusion of physical illness does not come as a surprise. The frequent representations of disordered brains are congruent with the effort to give meaning to a confused array of experiential phenomena comparable to the more formed delusion of a physical illness. Similarly, shifts in perceived locus of illness represent the patient's developing search for meaning of his experience of the psychosis.

Most interesting to us, however, are the unexpected elements of schizophrenic experience. When a patient chooses to portray his psychosis as a bleak depression, as in figure 11, we must recognize the depression as an especially significant component of the experience of the illness. The overwhelming prevalence of depression as the chosen representation of the illness was a surprising finding. Its occurrence during the acute phase as well as at recovery and followup suggests that it is found not only in the aftermath of the acute episode (so-called postpsychotic depression) but is present earlier, probably only masked by the more florid behavior of the acute phase.

A study of the same patient population conducted independently of the art evaluations demonstrated this same phenomenon using more traditional psychiatric assessment techniques (McGlashan and Carpenter 1975). This finding relates to an important phenomenologic issue currently debated in psychiatric nosologic circles. If the presenting psychotic symptoms are acute, or if depression is present, a question may be raised concerning the accuracy of a schizophrenic diagnosis (Feighner et al. 1972). We wish to underline the supporting clinical evidence presented in the method section above. We conclude that depressed affect is a common component of the acute schizophrenic break.

We were also impressed with the various expressions of positive feelings associated with the psychotic experience. Grandiosity with a euphoric element was, of course, not unexpected. But the quality of stimulation, excitement, and personal enthrallment with psychotic percepts was surprising, especially where mixed with frightening and confusing ideation. Finding the hospital a pleasant refuge from the turmoil of family life was noted by some of our patients.

In conclusion, we have attempted to describe patterns of schizophrenic experience expressed through art production. In both clinical work and research with the individual patients, a general response to acute schizophrenics' art expressions has been a recognition of the comprehensibility of schizophrenic experience and symptomatology. The pictures often have provided illumination of mystifying behavior. Through only three art sessions, it has been possible to increase our appreciation of the structure and content of the schizophrenic's individual reality, and to comprehend it as a reasonable consequence of his life experience.

An important benefit of art expression for psychotic patients is the undermining of the isolation experienced by an individual whose view of the world bears little resemblance to views held by those around him.

References

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorder.* 2nd ed. Washington, D.C., APA, 1968.

Carpenter, W. T., Jr.; Strauss, J. S.; and Bartko, J. J. Flexible system for the diagnosis of schizophrenia:

Report from the WHO International Pilot Study of Schizophrenia. *Science,* 182:1275-1278, 1973.

Feighner, J. P.; Robins, E.; Guze, S. B.; Woodruff, R. A.; Winokur, G.; and Murioz, R. Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry,* 26:57-63, 1972.

Garmezy, N. Process and reactive schizophrenia: Some conceptions and issues. In Katz, M.; Cole, J.; and Barton, W., eds. *The Role and Methodology of Classification in Psychiatry and Psychopathology.* Washington, D. C.: Superintendent of Documents, U.S. Government Printing Office, 1965. pp. 419-466.

Green, H. *I Never Promised You a Rose Garden.* New York: Signet, 1964.

McGlashan, T. H., and Carpenter, W. T., Jr. An investigation of the post-psychotic depressive syndrome. Presented at the annual meeting of the American Psychiatric Association, Anaheim, Calif., May 1975.

Phillips, L. Case history data and prognosis in schizophrenia. *Journal of Nervous and Mental Disease,* 117:515-525, 1953.

Plath, S. *The Bell Jar.* New York: Harper & Row, Publishers, 1971.

Wadeson, H. Portraits of suicide. Publication of exhibit at the annual meeting of the American Psychiatric Association, Washington, D.C., May 1971.

Wadeson, H., and Carpenter, W. T., Jr. Hallucinations and delusions. Publication of exhibit at the annual meeting of the American Psychiatric Association, Honolulu, May 1973.

Wadeson, H., and Carpenter, W. T., Jr. Pictorial presentation of hallucinations and delusions. *Japanese Bulletin of Art Therapy,* 5:97-104, 1974.

World Health Organization. *The International Pilot Study of Schizophrenia.* Vol. I. Geneva, Switzerland: WHO, 1973.

Acknowledgment

The authors wish to acknowledge appreciation to Patricia Nevius and Steve Karlin for their assistance in compiling the data.

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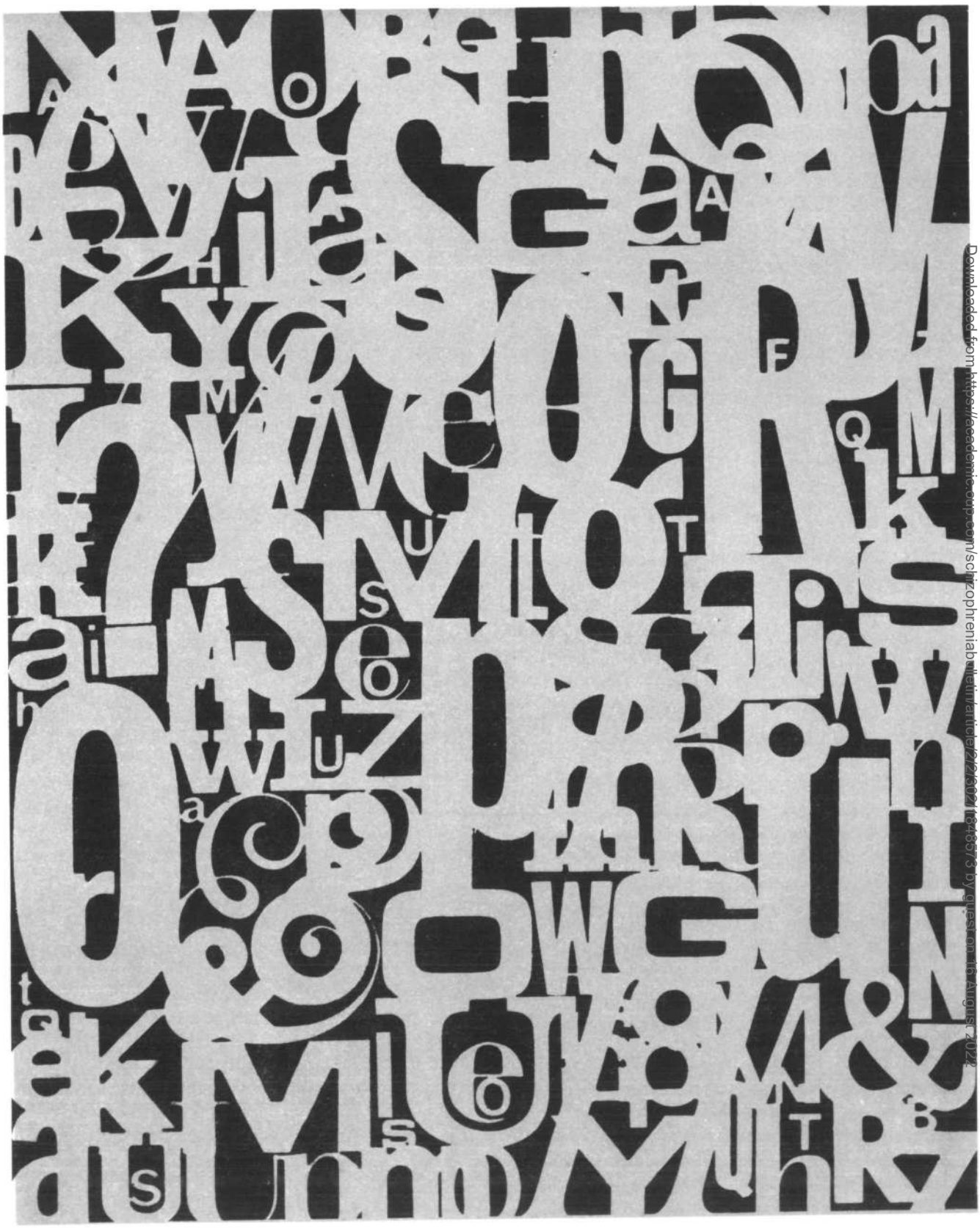

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