

DIFFERENT VIEWS OF A PSYCHOTIC BREAKDOWN – COMPLEMENTARY PERSPECTIVES OF A BEWILDERING EXPERIENCE

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SUMMARY

As humans we cope with incomprehensible and threatening experiences by creating our own theories about what is happening. In this study two psychotic patients and their therapists were asked to describe the patient's problem, its background and preferential treatment. To get a third perspective, Rorschach was administered to the patients. The interviews were repeated 6 and 18 months later. The narratives were compared and related to the outcome patterns. The most apparent difference was found in the theories about the cure. The Rorschach assessment was found to complement the interviews in a fruitful way.

INTRODUCTION

Experiences associated with a first-time psychotic breakdown can be described in different ways: from *within*, that is from the subjective perspective of the patient, and from *without*, that is from that of the close environment, including the family, work colleagues, neighbours, or from the professional expert perspective. None of the perspectives can be said to be more or less accurate or real than the others. Each has its own value, depending on what it is used for. The patient tries to understand and handle the anxiety-provoking experience by putting it in the context of previous life experiences. The care-givers, on the other hand, make observations related to the theories of their professional education. The medical staff mainly focus on symptoms and anamnestic information of importance for diagnosis and treatment-planning, whereas therapists, from their particular frame of reference, try to understand the problems and treatment needs of the patient from what is happening in the therapeutic relationship.

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The notions held by the patient are *subjective*, in the sense that they are influenced by his conscious and unconscious fears and wishes. The observations made by the professionals are perceived as *objective*, in the sense that they are seen as something that can be repeated and understood by colleagues in a more reliable way than can those of the patient.

The question in focus for this case study is whether the thinking of the patients is relevant in the treatment situation. Freud wrote that, although affected by psychotic functioning, the thoughts of the psychotic patient usually contain 'a kernel of truth' (Freud 1911 1937). Nevertheless, clinicians are seldom interested in, or even aware of, the patient's private theories about his illness and cure. His attempts to establish a sense of coherence and meaning to his situation are thus in the background, and the professional has become the expert possessing the knowledge needed for successful treatment.

In the same way as we think that the inclusion of the patient's perspective is important, we think that appropriate use of psychological tests can be helpful for a deeper understanding of the problem and its solution. In this study, a Rorschach assessment was made in connection with the first interviews. The test material was analysed, using Exner's Comprehensive System (Exner 1993). In addition, the responses were read in the same way as were the narratives in the interviews, that is, as the patient's response to the question implicit in the introduction to the test: 'In addition to the interview I would like to use a test to get a better understanding of the problem that brought you to the hospital'.

According to psychoanalytic thinking, the material offered in the *first* session, the *first* dream, etc. contains central information about the problems of the patient and his life situation (Stekel 1943, Greenacre 1975, Levenson 1976). On the analogy with these findings, only the spontaneous responses to the first three Rorschach tables were used for analysis. The hypothesized relationship between the interview and the Rorschach material was that the test responses would contain information about inner-life experiences not directly available to the patient, thus constituting a meaningful complement to the information offered in the interview.

In this paper, interview and test material from two first-time psychotic patients is presented, along with interviews with their therapists. The two patients were chosen from a group of six, who during a certain period of time were consecutively admitted at a Stockholm treatment centre in the National Health Service specifically designed for first-time psychotic patients. Each patient had his own psychotherapist with basic psychodynamic competence. The treatment offered to the six patients was the same as that available to all the patients at the centre. This study is the first in a series of naturalistic studies of 'private theories': first-time psychotic and long-term psychotic patients, psychosomatic patients, young adult psychotherapy patients with less severe problems, a non-clinical population and, currently, a group of patients in psychoanalysis (Werbart *et al.* 2002).

The interviews in this study were made approximately one week after the patients' first contact with the centre, and the patients and their therapists were asked the same questions:

- What is the problem that brought you/him to the psychiatric unit?
- What do you think is the background of the problem?
- What would be of help in the situation?

Further questions were used only for clarification. Each interview lasted for about 45 minutes and was preceded by no introductory contact. The interviews were repeated after 6 and 18 months. A long-term follow-up was made 7 years after the first interview. In this paper, the main focus is on the first set of interviews, because of our interest in the possibility of using early subjective reports from the patients for treatment-planning and diagnosis.

The interviews were tape-recorded, transcribed and analysed by three psychoanalytically trained, independent judges, using a systematic manual specifically designed for this phase of the work (Werbart and Levander 2000, Appendix 1). Finally, a consensus analysis of the interviews was worked out by the judges. The structural aspects of the Rorschach material were assessed by two psychologists experienced in the Exner System. The qualitative assessment of the contents of the responses can be evaluated from the text below. The patients were chosen because of their contrasting ways of thinking about what would be of help.

CASE DESCRIPTION: AXEL

Axel, a 23-year-old student, had slashed his forehead after returning from a successful tour as a musician. According to the clinical records, Axel was at the time hallucinating and occupied by delusional thinking. When he was interviewed he described his problem as memories that suddenly made him 'flare up', memories of something that he 'was not finished with'. 'It is as if I never left home, even if I have not lived there since I was 16'. He thought that the 'flaring up' was related to guilt-feelings towards his parents because of his difficulties in maintaining 'the right distance from them'.

He added that the 'flaring-up' had actually happened 3 months earlier, in an 'articulated bus from Stockholm airport', where he had chosen 'one of the single seats in between the two sections'. He also told that, 4 or 5 years earlier, everything had become too much for him; 'the problems caught up with me . . . and I felt I was an inferior person'. Another episode that he thought was related to his problems was when at the age of 14 years he was caught drunk in the central square of his home town. 'In the night of the 13th of December during the Lucia Day celebrations I was picked up by the police . . . who were friends of my father's'. Subsequently, he was

driven to the hospital with severe alcohol poisoning. 'Worst of all was that I afterwards never talked to my parents about it'. Another part of the situation was also that his classmates used to bully him because his parents were 'different', as they were the owners of the shopping centre in the town. When asked what would be helpful or what would alleviate the problems, Axel maintained that 'I have to learn to accept my background . . . and find a way to handle the relationship to my parents'. He thought that 'the fault' was his and that nobody could help him.

The therapist described Axel's problems as 'self-destructive and self-punishing . . . a lot of self-devaluation'. Axel had 'cut off his contact with his own history' when his parents let him leave home at the age of 16 years. He related the problem of 'a lack of communication in the family' to the fact that Axel's parents were 'not aware of Axel's needs'. The lack of communication was seen as the factor that made the police episode so destructive. In addition, the therapist saw Axel's slashing as an expression of his 'difficulties in accepting recognition as a successful performer, difficulties often seen in gifted and creative personalities'. The therapist thought that Axel needed to get support from his parents, to rest, and to 'get in contact with his childhood and to listen to his family talking about it, . . . in itself a way of communicating'.

In the third interview, 18 months later, Axel and his therapist were both discouraged. The therapist thought that Axel had 'a self-devaluation of delusional character' and needed more psychotherapy sessions, anti-depressive medication, and support by joining other patients at the day centre. Axel himself thought of leaving the treatment situation, wanting to manage by himself in doing something different, as the help and support from others did not work. At the same time he thought he would return to the therapist in the event that he did not manage by himself.

A comparison of the therapist's and Axel's notions of the problem shows that both described communication problems in the family, and they seemed to agree on the outer circumstances related to the problems. For the therapist, however, the fault was to be found mainly in the parents, whereas Axel saw it in himself. This probably relates to their different ways of thinking of the cure.

Rorschach test material

Axel's verbatim responses to the three first cards were as follows.

- Table I (1) Looks like a butterfly from Chernobyl.
 (2) Then like a mask. Looks malevolent.

- Table II (3) Looks as if this is the hole. It is bleeding . . . Would like to have a hole like that, a chap in the body . . . that would allow all of it to drain off . . .

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- (4) And the dark around. I don't know what is threatening . . . Like a UFO . . . and that is what I sometimes feel like.

- Table III
- (5) Two persons . . . Having a contact here. That part is the feeling that they have in common . . . But actually it is all about this other part up here. The first part is just a substitute. If this other part comes out, perhaps they would not be in contact.
 - (6) (Upside down) Now they have turned away from each other. They have built their walls.

To look at Axel's responses to the three first Rorschach cards as a form of narrative about his problems, the story might read as follows:

I feel like a contagious butterfly from Chernobyl, afflicted with something that is dangerous for myself as well as for those around me. Even if I try to cover it up, there is something evil inside me that I would like to get rid of – something that is threatening and abnormal. I wish it would drain off, so I didn't have to carry it with me. My contacts with other people might look OK, as if we were having something in common. But there is something behind the facade that threatens to destroy what is between us, so I might as well build some kind of wall around me to diminish the risk of causing even more harm than I have already done.

The structural analysis, according to the Comprehensive System, indicates that Axel's responses to a fairly high degree are coloured by psychotic functioning, since four out of the five criteria in the Perceptual and Thinking Disorder Index (PTI) are fulfilled. He seems introversive in his orientation (ideational, trusting internal evaluations), guarded and distrusting in relation to the environment, and with a strong – and probably delusive – subjective experience of control.

The interview transcripts and the test material seems to convey a picture of Axel as a psychotic young man, who for a long time had been fighting with conflict-laden aggressiveness towards his parents. It seems as if he had never been able to find a way to handle these feelings, e.g. to find the right distance to his parents. Either he was too far away, unable to reach them; or he came too close, a position laden with a destructive 'heat' that threatened to destroy them all. In retrospect, the parallel between the therapeutic situation and his previous life situation becomes sadly obvious. Axel wanted to move away from home (from the therapy), without really leaving it. He was not able to find 'the right distance' that allowed him to work with his anger and disappointment. Unable to get out of this position, he had to return, over and over again, to seek what he thought he had never had: a closeness – in particular to his father – which allowed for the kind of critique and opposition necessary for a father-son relationship with 'the right distance'. One interpretative hypothesis might be that the cutting of

his forehead was a desperate attempt to demonstrate and to get rid of his guilt for his aggressive wishes, at the same time as he, like Cain, hoped for a protection from the punishment threatening from somewhere.

All through the three interviews, Axel held on to the theory that a change *inside* himself had to take place, and that he himself had to do find a way to handle it. In the second interview, he even clarified his problem by saying that 'instead of getting angry I tend to dislike myself'. The therapist, who did not seem to be aware of this, thought that Axel needed support, to rest and to listen to his family talking about the situation. He was eager to help the family to establish contact, and perceived Axel's feeling that he himself had to take the responsibility for his problem mainly as depressive symptoms. In the third interview his thought that the cure for Axel would include medication, structured daily activities and more psychotherapy. None of the six interviews with the two of them indicated that attempts had been made to work with negative transference experiences. Thus Axel's wish to work with his difficult negative feelings, in a sense a wish for integration, never seemed to have been fulfilled. Rather, the therapeutic work over time appeared to become more and more supportive, and seemingly had some 'sealing-over'-quality to it.

CASE DESCRIPTION: ANDREAS

Andreas was a 29-year-old stockbroker, who was interviewed after almost a week at an acute psychiatric ward, where he had been treated with heavy neuroleptic drugs. When the interviewer asked him about his problem Andreas said 'late in the evening of the 30th October at the Heartbreak Hotel' he had been given a drink poisoned with cocaine and felt pursued by a foreign secret service. He spent the evening at the hotel with people from the company he had just started working with, the boss of which was a person 'whose policy I do not respect'.

Questioned whether there was anything prior to that episode that might be related to the problem, Andreas replied that the whole thing had started on 28 January of the same year in Copenhagen, when the company he was working for was sold 'to its worst rival'. The same day he had also found out that his girlfriend had been unfaithful to him for the past 8 months with an older man, who worked as a security manager; because of this he now had difficulties in trusting women. 'I was like a dog and wanted to satisfy all her wishes . . . (but) she only used me'. Maybe he felt 'a bit gayish, but I am not gay. . . . Not a king, just an ordinary lad from the countryside . . . Too helpful and good'. He also had a problem with the consultant doctor of the ward he had just left: 'I look at him in the wrong way, but I don't want to accuse him'. As to the significance of previous life experiences Andreas said that there was no need for going further back. 'I used to be the one in charge of order in the class and I come from a good and religious

family'. Asked about the help he needed, he replied that he would like to talk to his therapist 'in the evenings, but otherwise I want to work with my hands and with the books I am working with . . . I want to be in the present and to forget what's behind'.

The therapist described Andreas's problems in terms of 'persecutory and omnipotent ideas . . . The psychotic reaction was triggered by current strains, such as the new job and the decision to move into an apartment with his new girlfriend'. The therapist also thought that the stress dated back to the acute crisis, when Andreas found out about his girlfriend's unfaithfulness. It was a 'trauma, which he had not been able to deal with and which had not been worked through'. Finally he thought that Andreas's problems were connected with his personality, 'typical of people from the far northern region of Sweden, with insecurity and heavy demands on oneself'. The therapist's first notion of cure was that Andreas had to 'express and do away with all those difficult feelings amassed inside him after the painful separation'.

Six months later, Andreas presented his 'closet theory': He had used all his energy 'to close the ghost up in the closet', that is all the feelings that he was afraid of. When he had used his energy for other things, the ghost had slipped out and Andreas became psychotic. Now he succeeded in keeping the ghost in the closet.

Soon after the second interview, the patient, as well as the therapist, thought that Andreas had recovered, and they stopped seeing each other. In the third interview, Andreas still thought of himself as recovered. So did the therapist, who had not seen him for a year. He mentioned, however, that Andreas's 'self-confidence had been somewhat unrealistic' . . . and that he 'had difficulties reading the reactions of others . . . had been lacking in curiosity as to himself as a person . . . and had been too dependent on his mother'.

Rorschach test material

Andreas's verbatim responses to the three first cards at the time of the first interview were as follows.

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|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Table I | <ul style="list-style-type: none"> (1) Can be anything. Can look like a bird without a head. (2) Somebody has been turning on the wheel . . . a jar in the middle, that somebody has tried to make a bird from. (3) Can also be an aeroplane. But the cockpit is missing. (4) It can also be a leaf. |
| Table II | <ul style="list-style-type: none"> (5) There is something in the middle. It could be a church. Some kind of a temple. (6) The red around it has something to do with love. Something religious, a song about love to your neighbour. The black is |

- sin. Funeral. In Arabia you dress in white when you go to church. The synagogue perhaps.
- Table III (7) Much red. Love and eroticism. And black, sin and funeral. Something has died.
- (8) So I don't understand this . . . this hole. The *mons veneris* of a woman.
- (9) It can be an animal of some kind. A cat with a straight tail.

Andreas's narrative about his problems, as can be reconstructed from his Rorschach responses, is about a vague and confused experience.

I don't know what it is all about . . . It can be just anything. Actually I would prefer not to think about and get away from it all. It is something with love and hate, life and death. It's confusing and overwhelming and I would like to have something to hold on to; rules, religion or some other authority. There is too much emotion. Not only about affection and caring about people in general, but even more about love of women. I have got to sort out what is right and what is wrong, and if I am a real, sexual man or not. I am scared to death that all of that is over now.

The structural analysis of his Rorschach material gives a significant Perceptual and Thinking Disorder Index (PTI) with three of five criteria fulfilled. Also depressive and suicidal aspects are prominent, with a much more extensive style of orientation (impact of emotions leading to complex patterns of thought, tendency to count on external feedback) than that of Axel, but to the same extent lacking in the modulation of emotional experience.

The picture of Andreas appearing in the interviews and in the Rorschach assessment seems to be that of an orderly and 'good' young man. He had done his best to manage the demands he met in the 'dangerous' cities of Stockholm and Copenhagen, far away from his home town. However, everything came to an end, when his former girlfriend left him for an older man, and he was overwhelmed by a mixture of hitherto unknown, violent feelings of rage and sorrow, which he tried to lock up 'in the closet'. There are reasons to believe that the old rival (security manager) was a representative of Andreas's father, reactivating conflicting feelings, long since locked up and buried in his mind. Also the new boss in Stockholm and the head doctor in the hospital seemed to challenge him to struggle for his honour as a man and for what to him seemed righteous and good – a murderous wish probably hiding underneath.

The sexual aspect of the trauma comes out quite clearly in Andreas's two narratives. One interpretative hypothesis might be that the loss of the Copenhagen girlfriend also included a loss of a kind of sexuality that was strange (like that of dogs) but strongly attractive to him, as it confirmed

him in his role as a sexual man. All the unknown and confusing emotions had to be kept out of his mind, sealed over in an inner closet, for him to be able to continue onwards with a righteous and less complicated life, reminding him of the good and safe life of his childhood.

It should be added that the view held by his therapist corresponded to Andreas's view in many ways. Both seemed quite clear about the traumatic effect of the unfaithfulness of his former girlfriend. In the third interview the therapist even described Andreas's problem as a 'corpse in the closet', that appeared because of the strain of his social situation. In addition the therapist had some theories more related to his professional experience: 'personality disorders' and 'dependency upon his mother'.

As to the cure, their theories differed considerably. Andreas explicitly wanted to leave the painful situation behind, confirming his self-image by working with his hands, producing something he valued. The therapist, on the other hand, thought it was necessary for Andreas to uncover and work with his pain and feelings of having been offended in order to be less vulnerable to future strains. This, however, did not prevent him from acknowledging Andreas as an active person, taking responsibility for his own life.

DISCUSSION

The two patients thus conveyed their problems not only in terms of the symptoms which had been assessed as psychotic at the time of admittance, but also in their response to straightforward questions about their problems and, more indirectly, when Rorschach blots were presented to them with the simple question: What might this be?

As expected, each interview was coloured by the informant's subjective perspective. The narratives of the patients comprised a large amount of significant private information such as personal associations and memories of specific episodes, and their stories seemed to convey some central aspects of their inner situation. The therapists, who had just recently come to know the patients, seemed to have grasped a surprising amount of their thinking. In addition the therapists also responded in terms of more general diagnostic concepts belonging to their professional public theories: 'persecutive and omnipotent ideas', 'dependency on the mother' and 'difficulties accepting recognition'.

The two patients' private theories differed quite markedly, not only in respect to the problem formulations and the background but also to the cure that they thought was needed. Some available studies (Wile 1977, Abend 1979, Arlow 1981, 1986, Kleinman 1988, Daly 1991, Goldberg 1991, 1994, Werbart and Levander 2000) report findings indicating that the private theories of cure are usually intimately connected with theories about the background of the problems. What caused the psychotic breakdown also

belongs to the recovery process. What has occurred has to be undone; the disturbed harmony and balance has to be restored; what is missing or lost has to be supplied; what is dangerous has to be taken away or encapsulated; and so on. In the case of Axel, he saw the problem as belonging to his own personality (a lack of capacity to establish the right distance) and felt himself responsible for the change needed. Andreas 'locked the ghost up in the closet' and encapsulated the painful situation and the threatening emotions awakened by it. In clinical work this strategy for recovery is labelled 'sealing-over' and is usually associated with a lack of integration of the psychotic experience and, consequently, also with a less adaptable and durable solution (Levy *et al.* 1975, McGlashan *et al.* 1975, 1976).

Of interest is the possible effect of similarities or divergences between the theories held by the therapist and his patient. Does it make a difference if they think of the patient's problems and cure in the same way, or whether their theories go in different or even contrary directions? While six patients are too few to allow for any conclusions, the therapists of those patients who seemed to have a more positive outcome, either had theories that were more similar to those of their patient; or they knew of and respected the patient's views, even if they did not share them. This finding is paralleled by observations made in a German retrospective follow-up of psychoanalysis: the patient and the analyst recounted the same story in successful cases, reported the same key episodes, and had a shared view of the global results, whereas in the less successful cases the stories told by the patient and the analyst were so dissimilar that it was difficult to understand that they were talking about the same analysis (Leuzinger-Bohleber 2002).

As described above, we assumed that the responses to the Rorschach blots would include more preconscious and unconscious material than would the answers to the interview questions even if the psychotic functioning by definition indicates primitive defense mechanisms. To a certain extent this turned out to be right. Axel was aware of something being wrong, that there was something inside him that he was responsible for, but the Rorschach responses more clearly pointed to his overwhelming anxiety around destructive impulses. Andreas's interview responses, obviously more affected by psychotic confusion than those of Axel, on the other hand, conveyed at least as much psychodynamic information as did his Rorschach material. His thoughts of himself as 'a lad from the country, maybe gayish and definitely not a king' suggest a fear and uncertainty around male sexuality to the same extent as did the test material: 'Love and eroticism . . . And black, sin and funeral . . . Something has died'. Related to this is the finding that Axel, who did not convey signs of psychotic functioning in the interviews, produced Rorschach material that was clearly complementary to his manifest narrative where Andreas who seemed to function on a more psychotic level, openly talked about his underlying fears and fantasies in a way that corresponded to his Rorschach material. The fact that Andreas's

Rorschach on the structural level seemed less psychotic than that of Axel is difficult to evaluate on the basis of the data available.

Our primary intention has been to demonstrate that important information for treatment planning is available in the early phase of psychosis, if you go outside the usual psychiatric assessment procedures. Of course we will never know what would have happened had the choice of psychotherapeutic approach been different. What we *do* know today, 7 years afterwards, is that both of them have a regular job and have lived with a partner for several years. Andreas and his wife also have a 4-year-old child. Andreas never had a psychiatric contact after having left his therapist, whereas Axel had a serious relapse 2 years after the last interview. Since then he has been well and seems to enjoy his life situation.

Our hope is that this presentation can inspire a greater awareness of the possibilities of the approach described. We are also convinced that further work should be done to deepen our understanding of the role of subjective theories in the recovery process.

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