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## Neurotic symptoms' frequency

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*Independently of the diagnosis of the particular neurotic disorder, in symptom check-lists all patients note presence of some common symptoms. This fact disagrees with the fundamental concepts of contemporary systems of classification.*

*Key words:* neurotic disorders, diagnosis, symptoms, classification

The essence of “neurotic” disorders is not clear, even the very existence of such a disease is uncertain. This is a cause of quite frequent – perhaps more frequent than in other areas of psychopathology – changes in the diagnostic and classification concepts. The effects of all those attempts seem to be rather poor. Starting with past concepts of neurasthenia, psychasthenia or hysteria through “anxiety neurosis” or “depressive neurosis” to different types of “disorders” enlisted in contemporary manuals – they are inadequate to clinical reality [1, 2, 3, 4].

Perhaps it is unavoidable. Descriptions of syndromes (different neurotic disorders) are, due to necessity based on generalisations of partial observations (“incomplete induction”) which limit the accuracy of the constructed concepts. In consequence, these concepts are overlapping and not sufficiently separated. In the set of ICD-10 and DSM-IV lists of the diagnostic criteria of different disorders, the same symptoms (e.g. autonomic, sense of tiredness, anxiety, insomnia, difficulties in concentration, tension, irritability, etc.) are present [2, 4, 5]. So, in the majority of neurotic patients we can observe the presence of the same symptoms, considered as specific for the various disorders [6, 7, 8, 9]. It is one of the main factors which makes the diagnostic decision on the definite type of the disorder in a given patient very difficult. This inclines the formulation of complex, lengthy („snake-type”) diagnoses like “anxiety-depressive-neurasthenic syndrome with elements of obsession and conversion in a passive-dependant person”.

Paradigms of the ICD-10 lead to the hypothesis of parallel existence of different neurotic disorders in one person (co-morbidity) or to a hypothesis of mixed and complex disorders (“mixed depressive-anxiety disorder”, “agoraphobia with panic attacks”,

etc.). In research published in recent years, the co-existence of different neurotic disorders was noted in the majority (60-90%) of neurotic persons [9, 10, 11, 12, 13, and others]. The cases, where only one disorder is diagnosed are rather rare. Moreover, in such cases it seems that a clear, single diagnosis is a result of the selective perception of the diagnosing person. It seems to be also quite frequently the result of resignation from noticing in the diagnostic procedures, the symptoms considered as less intensive or less important, rather than the actual absence of the symptoms, specific for other disorders. The latter is implied by the answers of patients in the symptom check-lists. Usually they inform about the existence of some symptoms, which were not noted (or consciously not described) by the interviewer and are not consistent with diagnostic formula. It would thus seem that the diagnosis naming one neurotic disorder only, is more often than not, a result of the selective perception of the diagnostician (her/his cognitive schema, constructed by a diagnostic manual)[14,15].

Therefore contemporarily we observe the tendency to multiply the simple disorders, sometimes considered as “subtypes” (like in the case of social phobia) and to create strict diagnostic standards. This is accompanied by increased criticism of the solutions proposed by DSM-IV and ICD-10.

This criticism is especially directed towards to the suggestion of the existence of many different, relatively independent neurotic (or “anxiety”) disorders. Inadequacy of definitions and diagnostic standards is frequently stressed. The classification indirectly suggests of the existence of numerous independent illnesses, respective to the numerous independent disorders (descriptive syndromes). This confusing suggestion “works” in spite of the open declaration of purely descriptive (“phenomenological”) sense of diagnostic concepts. This suggestion is reinforced by the lack of consequence in the application of the rule of only descriptive concepts of “disorders”. Besides the specific symptoms, the diagnosis depends also on the time duration of the illness, stress exposure, etc.

Criticism is also directed towards resignation from the general category of “neurosis”. It is true, that such a general concept suggests the existence of one disorder, which has a different symptom configuration, depending on additional and changing circumstances. This hypothesis is not sufficiently proved. The hypothesis of the multiple different neurotic disorders existence is not proved as well, however.

Therefore the usefulness of the diagnostic rules and procedures proposed by ICD-10 seems very doubtful. We do not have however, any other more accurate means of ordering the variety of neurotic disorders psychopathology. The question of the existence of some symptoms common in every neurotic case appears to be crucial.

### **The aim of the study**

The aim of the study presented was to make an attempt to determine which symptoms – somatic, psychic and behavioural dysfunctions – are more frequent, and which are less frequent in the whole population of ill persons admitted for therapy in a unit specialised in treating neurotic disorders. Additionally, the similarities and differences in the symptom frequency in the subgroups of women and men were analysed.

## Material and study method

The study material is 3196 symptom check-lists 'O' (SCL-O) [16] filled out by patients (1970 women and 1226 men in the age from 19 to 68) in the years 1978-1997. Majority of these were filled out at the time of ambulatory diagnosis which confirmed the necessity for therapy in psychotherapeutic day-wards (46 persons filled out the questionnaire in the first day of therapy). The whole number of patients whose symptom check-lists were analysed is about 89% of all persons (3585) treated in that time. (Questionnaires in which there was more than three items unchecked, where the computer data was inadequate, etc. - were not taken into account.)

The diagnosis with which the patients were directed for treatment and the final diagnoses varied in time, in their description and they were depending on, amongst others the actually abiding classifications, changes of diagnoses during the course of longer therapy etc. Therefore, it is possible only to roughly describe that - by applying the ICD-10 terminology - in the time of treatment commencement about 25% of patients had predominantly anxiety disorders ("in the form of phobias" and "other anxiety disorders"). In ca. 20% of this population somatiform disorders were diagnosed, in ca. 15% dysthymia, ca. 15% - dissociative disorders (conversive) and ca. 5% obsessive-compulsive disorders were diagnosed. The remaining 20% were "other neurotic disorders" - mostly neurasthenic syndromes, "behavioural" - mainly eating disorders, some (few) cases of acute stress reactions and patients with more personality than neurotic symptoms.

SCL-O is a questionnaire derived from the SCL-90. The most important difference is the exclusion of "psychotic items" of SCL-90, scales of psychoticism, paranoid ideation and an enrichment of the description of neurotic symptomatology. The correlation between SCL-O and SCL-90 is high (0.9), however the GSI of SCL-O is much more reliable for neurotic disorders' evaluation, due to the above mentioned elimination of the SCL-90 scales. Subjects note the presence of the given dysfunction in the 7 days before filling out the symptom check-list.

When completing a taxonomic analysis, SCL-O delivers in common one general factor. This does not depend on the sample of neurotic patients' specific disorders or their other characteristics. Despite this, psychometric procedures help to subdivide items into fourteen structured scales.

The norms for the SCL-O are 200 weighed points for women and 165 for men. Below the norm some points can be connected with some somatic or other, not neurotic disorder.

In the reported study 95 items mostly pertaining to neurotic disorders were chosen from the 138 items present in the questionnaire. Only presence or absence of symptom was considered (omitting the information about symptom intensity). Assessment of the symptom frequency was made on the whole population and - separately in subgroups of women and men. Statistical significance in the difference between the mean frequencies of symptom presence in women and men was based on the test for two structure coefficients, measures from independent trials\*.

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\* Statistical evaluation made by Jan Przetacznik, M.A. from the Department of Psychology of Work and Ergonomics at the Institute of Psychology of the Jagiellonian University.

The results are presented in the tables where the variables are placed depending on the average frequency of symptom presence in the whole population (women and men together), with the application of symptom names – which at times differ from the formulation used in the questionnaire. (Variables of the questionnaire to which the numbers in the tables pertain, are for obvious reasons applying common language, not the language of psychopathology.)

## Results

Table 1

SYMPTOM No. pertains to the sequence of the question in the symptom check-list "O"	SYMPTOM FREQUENCY IN THE POPULATION			
	Whole group (3196)	Women (1970)	Men (1226)	Female-Male significant differentiation
16 feeling of tension	96,4%	96,3%	96,4%	Not significant
2 lowered mood	95,5%	96,6%	93,6%	0,001
64 uneasiness	93,7%	94,9%	91,85	0,001

Tension, lowered mood (worryness) and uneasiness are present in almost all of the patients (90% of the population), independently of the type of neurotic disorder that was diagnosed; similarly in women and men. Although lowered mood and uneasiness are significantly more frequent in the subgroup of women, the differences are only by about 3%.

Table 2

SYMPTOM No. pertains to the sequence of the question in the symptom check-list "O"	SYMPTOM FREQUENCY IN THE POPULATION			
	Whole group (3196)	Women (1970)	Men (1226)	Female-Male significant differentiation
66 difficulty in concentrating	88,5	89,0	87,5	Not significant
35 uncertainty	88,0	89,4	85,7	0,01
86 tiredness	87,5	88,9	85,2	0,01
102 loss of energy (lowered activity)	82,8	86,1	77,4	0,001
18 persistent thoughts, words, ideation	82,2	82,2	82,2	Not significant
4 persistent anxiety	80,7	84,4	74,9	0,001
36 absence of mind	80,4	82,5	76,9	0,001
56 "nervousness", motor tension	80,1	81,9	77,3	0,01
82 pessimism	79,9	83,2	74,6	0,001
126 preoccupation of thought	79,3	80,1	78,2	Not significant
106 difficulty in thinking	79,3	81,2	76,3	0,001

11 other symptoms were noted in the questionnaires with almost the same high frequency (79%-89% of the whole population). This is obviously disproportionate with the frequency of the diagnoses (e.g. anxiety disorders – about 25%, obsessive-compulsive disorder in about 5%). These symptoms are more common in the sub-group of women (statistically significant values in 8 of the 11 variables). Differences between the average results are from 3.7% (variable 35 and 86) to 9.5% (variable 4 – persistent anxiety).

The next group of 15 symptoms, which were also present unexpectedly frequent (60-75% of the population) is presented in table 3.

Table 3\*

SYMPTOM No. pertains to the sequence of the question in the symptom check-list "O"	SYMPTOM FREQUENCY IN THE POPULATION			
	Whole group (3196)	Women (1970)	Men (1226)	Female-Male significant differentiation
10 discomfort in social situations	74,6	74,3	75,1	Not significant
75 low self-esteem	74,4	77,9	68,9	0,001
26 memory impairment	74,4	76,6	70,9	0,001
72 movement and thought inhibition, apathy	74,4	78,6	67,4	0,001
84 feeling of an uncertain endangerment	72,1	73,2	70,2	Not significant
39 difficulty in falling asleep	69,4	67,7	<b>72,0</b>	0,05
77 anxiety about being ill with a severe illness	67,7	67,4	68,3	Not significant
12 compulsory task performance	67,4	67,9	66,6	Not significant
22 feeling guilty, blaming oneself	67,1	70,1	62,3	0,001
79 frequent awakening at night	64,5	65,9	62,1	0,05.
119 hypersomnia	64,1	65,0	62,7	Not significant
17 finding signs of different illnesses in oneself	63,4	61,9	<b>65,7</b>	0,05
116 constant anger, irritation	62,8	62,5	60,0	0,05
50 avoiding people, even close friends	62,5	64,1	60,0	0,05
99 "insomnia"	61,4	61,0	62,1	Not significant

The frequency of the generalised social phobias (variable No 10) and compulsions (No 12) is surprisingly significant. Amongst symptoms sleeping disorders, come

\*In the tables, values noting the higher symptom presence frequency in men, are denoted in bold text.

are more frequent in the subgroup of men (variable No 39), some in the subgroup of women (No 79). Dysthymic symptoms were more frequent amongst the women (No 72 – by 11.2%, No 75 – by 9.0%, 22 – by 7.8%), while the symptoms of hypochondriac disorder (e.g. variable No 17) were more frequent amongst the men.

Table 4\*

SYMPTOM No. pertains to the sequence of the question in the symptom check-list "O"	SYMPTOM FREQUENCY IN THE POPULATION			
	Whole group (3196)	Women (1970)	Men (1226)	Female-Male significant differentiation
21 anxiety in loneliness, e.g. in an empty flat	59,0	63,2	52,3	0,001
24 strong, permanently present generalised anxiety	59,0	61,8	54,5	0,001
65 lack of control in emotion expression	58,7	62,2	52,4	0,001
5 tendency to cry frequently	57,5	76,6	26,5	0,001
57 constant observation of body functions (pulse, digestion, etc.)	56,9	55,3	<b>59,5</b>	0,05
54 loss of appetite	53,6	56,6	48,7	0,001
67 severely lowered or absent sexual drive	53,0	54,1	51,3	Not significant
97 conviction about being severely ill somatically	51,8	48,8	<b>56,6</b>	0,001
109 hyper photo-, audio- and tactile-sensitivity	50,8	55,1	43,8	0,001
37 exaggeration in trying to avoid illness	50,5	50,3	50,8	Not significant
95 daydreaming	50,0	47,9	<b>53,3</b>	0,01

Amongst the 11 symptoms whose frequency (50-60% of the population) is presented in table 4, the difference of symptom frequency of crying in women and men is striking (variable No 5 – difference by 50.1%). Also striking is the high frequency of daydreaming amongst the men (variable No 95). The frequency of hypochondriac disorder was higher just like the other, more frequent symptoms of this type (table 3) – amongst the male population.

Table 5 depicts the frequency of 16 somatic dysfunctions noted by more than 50% of the studied population. Tachycardia and hyperhidrosis was noted in the check-lists by about 80%, the remaining symptoms were present amongst 50%-70% of the population. All of the symptoms were more frequent amongst the female population (the biggest differences: "globus histericus" – 14.3% and vertigo – 13.6%).

Table 5\*

SYMPTOM No. pertains to the sequence of the question in the symptom check-list "O"	SYMPTOM FREQUENCY IN THE POPULATION			
	Whole group (3196)	Women (1970)	Men (1226)	Female-Male significant differentiation
20 tachycardia	80,2	82,5	76,4	0,001
114 increased sweating	77,1	79,3	73,4	0,001
89 muscle fibrillation, trembling	69,5	72,1	65,3	0,001
14 head spinning	68,2	73,4	59,8	0,001
40 chest pain in the area of the heart	65,9	68,6	61,5	0,001
134 muscle aching – e.g. in the lower vertebral region, etc.	65,2	67,0	62,3	0,01
29 headache	65,1	69,1	58,6	0,001
3 feeling of having a ball in the throat ("choking", "globus")	64,0	69,4	55,2	0,001
60 "hot-flushes", "cold-spells"	63,0	67,9	55,0	0,001
129 muscle tension	60,5	62,8	56,7	0,001
103 lack of breath, dyspnoea	59,9	64,3	52,9	0,001
49 dry mouth	59,2	61,5	55,5	0,001
113 trepidation of eyelids, face, head, etc.	57,4	58,5	55,7	Not significant
34 feeling of blood rushing to one's head	57,3	58,7	55,1	0,05
117 uncertain "migrating" aches	50,9	53,0	47,6	0,01
123 lack of balance	50,2	54,4	43,4	0,001

39 symptoms, which were noted by less than 50% of the population are depicted in table 6 (next page). This table has been for simplicity divided into 4 parts, depending on the connection of the symptoms with the type of the disorder (more common symptoms connected with these disorders were listed in tables 1-5).

Most of these symptoms are more frequent amongst the women. More frequent (statistically significant) amongst the men were only three somatic symptoms (heart-burn, tics and stuttering); some sexual dysfunctions – ejaculatio praecox or erectile dysfunction (in comparison with the frequency of e.g. vaginismus), as well as obsessive thoughts and ideation of blasphemous content. These former ones were noted in 17.3% more men than women. The differences in the presence of the other four obsessive-compulsive symptoms were not statistically significant.

Only 12 symptoms were present in less than 30% of the population, the most uncommon of them being fainting.

Table 6 – A, B, C, D

SYMPTOM No. pertains to the sequence of the question in the symptom check list "O"	SYMPTOM FREQUENCY IN THE POPULATION			
	Whole group (3196)	Women (1970)	Men (1226)	Female-Male significant differentiation

**A: ANXIETY DISORDERS IN THE FORM OF PHOBIAS  
AND OTHER ANXIETY DISORDERS:**

81 anxiety when being in a crowd	48,7	52,2	43,1	0,001
1 anxiety on balconies, bridges, on the edge of a precipice	47,3	49,7	43,3	0,001
44 panic attacks	46,8	51,1	40,0	0,001
124 feeling afraid of losing control, catastrophic anxiety	46,7	49,6	41,9	0,001
70 difficulty in contacts with persons of the opposite sex	41,7	42,1	42,5	Not significant
71 anxiety in closed spaces	40,4	44,7	33,5	0,001
41 anxiety in vehicles – trains, buses, etc.	39,1	42,9	33,0	0,001
101 specific phobias – animals, objects and places	35,5	36,3	34,1	Not significant
61 anxiety in open spaces	26,3	28,6	22,4	0,001

**B: SOMATIC DYSFUNCTIONS  
(ALSO CONVERSIONS AND SEXUAL DYSFUNCTIONS):**

136 nausea, feeling sick	46,8	51,0	40,0	0,001
93 muscle cramps in different areas of the body	46,7	47,5	45,4	Not significant
80 getting red on the face, neck	45,4	49,4	38,8	0,001
137 lowered libido	44,4	43,7	45,5	Not significant
31 flatulence, unknowing passing of winds	43,0	44,0	41,5	Not significant
13 muscle cramp when doing something (e.g. writing)	42,9	43,6	41,7	Not significant
135 buzzing in one's ears	42,4	44,3	39,3	0,01
131 burning sensation in one's throat, heartburn	40,4	37,7	<b>44,6</b>	0,001
74 constipation	38,9	46,1	27,2	0,001
11 skin itchiness, passing rashes	38,2	41,1	33,6	0,001



53 tics – sudden, body movements independent of one's will	36,0	34,0	<b>39,3</b>	0,01
63 temporarily loss of eyesight or hearing	34,4	36,8	30,5	0,001
83 faintness	30,6	34,8	23,8	0,001
27 vaginismus or ejaculatio praecox or lack of erection	30,4	26,5	<b>36,7</b>	0,001
69 diarrhoea	29,2	29,2	29,1	Not significant
23 temporarily loss of touch or pain sensation	26,5	29,3	22,1	0,001
33 stuttering	25,6	23,5	<b>29,0</b>	0,001
73 temporarily speech-loss	25,5	25,5	25,4	Not significant
9 vomiting in situations of nervousness	23,2	27,2	16,9	0,001
43 momentarily paresis of hands or limbs	22,2	23,4	20,5	Not significant
51 fainting	17,6	19,9	13,9	0,001

#### C: OBSESSIVE-COMPULSIVE DISORDER:

32 need to unnecessarily repeat actions	47,3	47,9	46,5	Not significant
52 need to wash one's hands, touch objects, etc.	41,3	40,2	43,1	Not significant
92 need for slow, pedantic action	40,6	41,4	39,2	Not significant
58 blasphemous or indecent thoughts and ideation	30,0	23,4	<b>40,7</b>	0,001
38 obsessive thoughts of an aggressive character	29,8	28,7	31,4	Not significant
78 need to count lampposts, cars, etc.	25,1	25,8	23,8	Not significant

#### D: DEPERSONALISATION AND DEREALISATION SYMPTOMS

48 feeling of the world as unreal	34,5	35,4	33,1	Not significant
8 feeling of unreality of certain objects	25,3	26,6	23,3	0,05
68 feeling of unreality, strangeness of one's own body	20,5	21,7	18,6	0,05

## Comment

The answers given by the patients in the symptom check-lists before treatment commencement suggest that many dysfunctions, (especially emotional and somatic-autonomic) are unexpectedly common, independently on the type of the disorder and do not correspond to the percentages of diagnoses presented in the studied population.

12 symptoms present in at least 4/5ths of the studied population (frequency of noting in the symptom check-list above 80%) are – besides generalised anxiety, different forms of tension and lowered mood – cognitive function impairment, in this, obsessive thoughts and ideation and one symptom of autonomous arousal (tachycardia). Not much less commonly present is another symptom from this group (77%) – hyperhidrosis and 3 others: pessimism, preoccupation of thought and a feeling of difficulties in thinking (about 79%).

Taking into account that in the analysed set of questionnaires were also those filled out by persons with personality disorders, it seems that these 16 symptoms are quite common and rather constant elements of every neurotic disorder. They are not specific for any of the “disorders” noted in the DSM-IV and ICD-10.

Altogether, from the 95 analysed symptoms, as much as 39 (about 41%) were present in more than 60% of the population, and 56 (about 59%) in more than 50%. Amongst these that were present in more than half of the population are obsessive thoughts and ideation, compulsions, social phobia manifestations, hypochondriac attitude and anxiety, various somatic dysfunctions together with autonomous arousal and tension (see table 5), as well as elements of “behavioural syndromes”: sleep dysfunctions, sexual dysfunctions and eating disorders. It is also much more than could be expected from the impact of different disorders in the pool of patients (the most common was the subgroup of anxiety disorders, about 25% of the whole population).

Most of the symptoms noted was statistically significantly ( $p < 0.05$ ) higher amongst women than men (57 of the 95 symptoms – 60%). 10 symptoms were more common in men, in 28 cases (about 30%) the differences were not statistically significant (7 of these symptoms were noted as a little more frequent amongst the men).

## Discussion and conclusions

The presented results, suggesting that patients ill with different neurotic disorders have many common symptomatic traits (a lot more than is generally considered) should be taken cautiously due to two reasons at least. First of all the frequency of a given dysfunction presence in the population of persons treated, in a large way depends on the type of patients directed to a specialist therapy of neurotic disorders. Hence the results described cannot be considered as a general information on the picture of these disorders. It cannot be ruled out that certain symptoms are more likely to cause someone to take up treatment, than others – therefore they are represented more frequently amongst patients than in the general population of the ill. On the other hand, significant differences in the clinical picture of the neurotic disorders of persons that

do not take up treatment and persons seeking therapy, appears unlikely. Secondly, the manner of understanding the questions in the symptom check-lists is very different, depends not only on the education and the knowledge of the patient, but also on other factors – level of tension, ability to be introspective, etc. It cannot be said for sure that the answer, which denotes the presence of a given dysfunction, does really inform about the existence of such a symptom. (So, the necessity for a 'translation' to be made causes extreme caution also in the interpretation of the results.)

There are however sufficient reasons for considering the answers in the symptom check-list to be a fairly genuine source of information on the picture of neurotic disorders. The question then arises on the cause of the disproportion between the number of symptoms, which are supposed to decide on the diagnosis of the given disorder and the number of the patients adequately diagnosed. It may be due to the fact that during the psychiatric interview symptoms that are considered as secondary by the patient are omitted. The role of cognitive schemas made by the classifications of disorders cannot be ruled out also. Diagnosing persons have a tendency to note only the symptoms suggested by the diagnostic manual.

Henceforth, results from the presented study may be treated only as another signal which impairs the conviction of accuracy of the modern views on the structure of symptomatic syndromes which make up neurotic disorders and the classifications that arise from them. They do not bring about a univocal information on that what is the real picture of this structure, they do however have pointers allowing for the further study direction.

The most important conclusion appears to be the existence of a "common core" of "neurotic stress-related and somatoform disorders". Tension, lowered mood, uneasiness, difficulty with concentrating, uncertainty, tiredness, loss of energy, obsessive thoughts and ideation, constant anxiety, absent-mindedness, motor tension, pessimism, preoccupation of thought and difficulty in thinking as well tachycardia are all a part of it.

The many years in which the material was collected (20 years) allows for an assumption that the frequency of these symptoms is not a result of some temporary socio-cultural circumstances. Such an effect on constant presence of such circumstances in the milieu of the region from which the majority of patients were recruited cannot be excluded – the determination of the effect of these variables requires trans-cultural research however.

It would appear that these results point to a purposefulness of singling out the group of disorders called "neurotic". Perhaps also to the hypothesis of the existence of one disorder – "neurosis". The symptoms of this disorder (different from "axial symptoms" considered in the past) are constantly coexisting in those suffering from this disorder.

On the other hand, the commonness of tension, lowered mood and uneasiness can be the effect of unspecific pathoplasmic factors, causing for a health disorder to arise in a situation when an individual loses the hope to deal with the current difficulties ("de-moralisation", using the term of Jerome Frank). These factors do take part in the development of different disorders. Therefore the presence of these three most fre-

quent symptoms, despite their commonness, can mean not the existence of a neurotic disorder – unless it will be possible for a qualitative differentiation between the “neurotic” forms of these symptoms and the same type of symptoms connected with other health disorders (non-neurotic). A similar frequency of depressive symptoms, anxiety and obsessions can be also the result of some disturbance in the process of neurotransmission causing their formation, and not the specificity of neurotic disorders (or “disorder”?).

Perhaps this “common core” is rather thought disorders, anxiety and lowered life dynamics, noted in more than 80% of patients (table 2).

These symptoms are considered – similarly to those present in 50%-80% of the treated population (see tables 3, 4 and 5) – as specific for the particular disorders mentioned in DSM-IV and ICD-10 classifications. The presented results make this difficult to agree with.

The presence of such complaints in a large number of patients (e.g. obsessive thoughts – 82.2%, psychomotor retardation, apathy – 74.4%, feeling of uncertain endangerment – 72.1%) can be explained by the commonness of the phenomenon of “co-morbidity”. However the question arises: does the constant coexistence of a few different disorders allow for considering them as separate? Similarly – frequency of dysfunctions, considered as symptoms of behavioural syndromes (50%-60% of the population) can be a signal of the frequent coexistence of these different disorders as well as an argument against the adequacy of separating neurotic disorders from “behavioural” ones.

Another conclusion arising from the results presented is the necessity for a verification of the existing conviction on the connection between the symptomatology of neurotic disorders and the gender of the patients and the differences arising from this. The study did confirm that the majority of the analysed symptoms is more frequent amongst women than men (especially crying), that the symptoms of hypochondriac disorder are more common in men, while obsessive-compulsive symptoms are equally frequent, irrelevantly of gender etc. The results do suggest however that the mentioned higher symptom frequency in the sub-group of women is in general not so large (few to more than ten per cent of the population). The amount of symptoms equally frequent in both sexes (about 30% of the 95 symptoms analysed, at a statistical significance level of  $p < 0.05$ , and about 39% at a level of  $p < 0.01$ ), as well as the information that about 10% of the analysed symptoms are more common in men – suggest the adequacy for seeking rather similarities than differences.

Perhaps, the regularity of co-existence of many symptoms is specific for neurotic disorders [17, 18, 19,], and the changing of the types of these symptoms does not mean the coexistence of many different disorders, but the transformation within one system, which is made up of many elements [18]. As it appears that some of them are present relatively constantly, others less frequently, perhaps due to other additional circumstances.

The phenomenon of the changing of the frequency of some symptoms and stability is the subject of another study. The results of these analyses will be the subject of further publication.

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