Archives of Psychiatry and Psychotherapy
Volume 8, Issue 3, September 2006
pages 23–36

Pretherapy symptom level changes

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Summary

Aim. Description of global neurotic symptom level present during pre-therapy waiting.

Material. Case records of 2589 patients containing two symptom checklists filled in before treatment in a day-hospital.

Method. Analysis of symptom change, by comparison of symptom checklists "0" filled in whilst waiting for therapy – at the first diagnostic ambulatory visit and on the day of psychotherapy admission.

Results. Changes of the global symptom level during pre-therapy assessment and pre-therapy waiting were not large but they were composed of frequent changes in both incidence and intensity of particular symptoms. On average only 40-60% of the symptoms (the same) were present in both measurement points during pre-therapy waiting. Similar rates of such changes were observed in women and men.

Conclusions. Global symptom changes among individuals waiting for therapy were relatively small in most cases. However, in particular symptoms many different and very heterogenous transformations were observed. Patterns of change were gender-independent in the global symptom intensity as well as in the particular symptom rates.

Key words: neurotic disorders symptoms, symptom dynamics, pretherapy waiting, waiting list, psychotherapy research

Introduction

Waiting for treatment is a period that is apparently not connected to having any influence on a patient. That is why groups of individuals waiting for beginning treatment (so called waiting lists) are often used as "control" groups for comparisons with the treated groups.

However, it was observed, that sometimes even major changes in neurotic disorders intensity occur in untreated persons; these being "spontaneous improvement" as well as deterioration [1, 2, 3]. As M.Lambert stated (quotation by S.Kratochvil) frequency of spontaneous remissions is assessed as ca. 40% [4]. Sometimes such improvement is only apparently "spontaneous", because during the period of waiting for treatment – especially prolonged waiting – the persons may be utilizing a variety of influences improving their health status, e.g. pharmacotherapy by doctors of different specialties [5, 6]. The fluctuations of symptom level may also be affected by factors such as life situation changes, family support etc. [e.g. 7, 8, 9].

The phenomenon of significant symptom improvement during waiting for treatment is often explained by the influence of hope and support gained by patients, both being strong non-specific therapeutic factors. Causes of decrease of symptom intensity may be relevant to such factors as e.g. initial examination and anamnesis (sometimes being a kind of "catharsis"), feeling of safety resulting from obtaining a diagnosis, explanation of treatment rules and setting the term of its beginning [3, 4, 7, 10, 11, 12, 13]. Improvement may be also a consequence of sporadic, only apparently "pure" diagnostic contacts with therapists, signs of their interest, influences of prestige and the evoked positive expectations towards the treatment [5, 14, 15, 16, 17, 18, 19]. It was observed that even setting the time of the first meeting resulted in a significant decrease of symptoms in 15-40% of the patients [16, 20, 21, 22].

S. Leder [10] compared the influence of waiting for treatment to the function of the first phase of therapy (passive learning). That thesis seems to be confirmed by results of a study by B.Pawelec et al. [23], who described large decrease of symptoms intensity in patients oriented on secondary gains, who wanted to obtain fast symptom improvement with minimal own involvement.

Decrease of symptoms, as well as their increase may also be connected to processes of insight initiated during the selection for treatment (e.g. recollection of context of first symptom emergence). Worsening may result from fear of new situation, treatment as such or stigmatisation connected to psychiatric treatment.

Report of symptoms intensity made by a patient is connected to some specific characteristics of measurements with the use of symptom self-reports (checklists), e.g. their result may by dependent on the context of examination (e.g. benefits from simulation or aggravation). Despite those limitations, information obtained from patients' self-report questionnaires is commonly estimated as useful for diagnostic and research purposes [9].

Aim of study

This research was aimed at the analysis of the global symptom intensity changes observed during the waiting period, consisting of changes of occurrence and intensity of separate symptoms.

Hypothesis

During the period of waiting for treatment one can observe changes of the kind of symptoms and their intensity which brings about an impression of improvement or deterioration of patients' health status.

Material and methods

Symptom checklists filled-in by 2589 patients (1777 women and 812 men) waiting for psychotherapy in a day-hospital were the study material. Neurotic disorders were the main diagnosis or they were comorbid with personality disorders or eating disorders. The research group of 2589 patients constituted circa 70% of total population

treated in the day-hospital in 1985-2002, (information regarding persons readmitted for treatment, persons diagnosed with disorders different than neurotic disorders etc. were omitted). During the period of waiting for starting treatment, all patients filled-in the symptom checklist twice: 1) on the day of the first visit in the ambulatory clinic, during examinations starting the diagnostic procedure and selection for the psychotherapy process, 2) on the day of admission to psychotherapy, before the first group session. Time interval between these two measurements was different and depended on the speed of examinations and time of waiting for a free place in the ward (ranged from one week to some or even several dozens of weeks). In each patient the Global symptom intensity, was higher in at least one point of measurement before treatment than values typical for healthy persons (above 200 points for women and above 165 points for men).

The difference between two measurements with the symptom checklist KO "0" [24] was estimated, in terms of (1) global intensity of symptoms, and (2) changes in occurrence and intensity of particular symptoms. These changes were analysed for every patient separately in terms of:

- placement of the value of global symptom intensity level (OWK) in one of the analysed measurements to a spectrum typical for the ill population or typical for healthy persons [25],
- size of change of OWK in the second measurement (in terms of categories: major improvement, minor improvement, no change, minor deterioration and major deterioration) where the change index was coefficient XO [26, 27],
- proportion of changes in occurrence and intensity of particular single symptoms consisting the global symptom level. All 135 symptoms (items) were analysed, with the estimation of:
  a) occurrence of a symptom during the waiting for treatment period (in the first or the second measurement),
  b) appearance of a symptom, not present at initial examination in the ambulatory clinic and in the measurement on first day of therapy in the day-hospital,
  c) disappearance of a symptom before starting treatment in the day hospital,
  d) increase of intensity of a symptom present in both measurements,
  e) decrease of its intensity,
  f) constant intensity of a symptom in the waiting for treatment period.

Gender of patients was included in analyses. Significance of differences between rates was tested with two-tailed test for fractions. Distributions were compared with Kruskal-Wallis test and the median test. Relations of duration of waiting and size of intensity and occurrence of symptoms were also examined with correlation analyses.

Results

For 2327 patients (ca. 90% of the research group, because some case records were not available) the time between filling the first and the second questionnaire (time of waiting for treatment) was specified. Results (in months) are presented in Table 1.

Table 1

Time of waiting for treatment

Months	Number of patients	%
1	259	16.1%
2	335	20.9%
3	300	18.7%
4	215	13.4%
5	159	9.9%
6	77	4.8%
7	62	3.9%
8	38	2.4%
9	37	2.3%
10	25	1.6%
11	27	1.7%
12	18	1.1%
13	15	0.9%
14	7	0.4%
15	8	0.5%
16	9	0.6%
17 and more	14	0.9%

Data for 2327 patients (90% of the group), for whom length of time between filling checklists was estimated.

As it is shown in Table 1, majority of patients waited for therapy not longer than half a year (83%), more than half of patients (55%) shorter than 4 months, and only 3% of ill persons waited longer than 12 months. Average waiting time was significantly longer for women ($p<0.0001$, Table 2).

Table 2

Time of waiting (weeks) and gender of patients

Women (n=1605)	M±SD; Me(Q1, Q3)	① 15±14; 11(6, 19)
Men (n=722)	M±SD; Me(Q1, Q3)	① 11±11; 8(4, 15)

M – mean, SD –standard deviation, Me – median, Q1 – lower quartile, Q3 – upper quartile. Data for 2327 patients (90% of the group), for whom length of time between filling checklists was estimated, ① difference statistically significant with level $p<0.0001$

As it is shown in Table 3, in the great majority of future patients (ca. 90%), during the waiting for treatment period global symptom intensity (OWK) persisted. This confirmed the presence of neurotic disorders. Only in 8% of the research group one

could observe a decrease of global symptom level, causing that at the admission to the day-hospital, the OWK value was smaller than typical for people suffering from neurotic disorders (200 points for women and 165 points for men). The least frequent was an increase of intensity of symptoms from values not indicating neurotic disorder to values typical for neurotic patients (Table 3).

Table 3

Global symptom intensity in the period of waiting vs values typical for ill persons

Gender	Continously above 200/165 pkt.	Decrease below 200/165 pkt.	Increase above 200/165 pkt.	Total
Women	1576 – 89%	①153 – 9%	① 48 – 3%	1777 – 100%
Men	718 – 88%	② 66 – 8%	② 28 – 3%	812 – 100%
Total	2294 – 89%	③ 219 – 8%	③ 76 – 3%	Total 2589

All differences between groups of women and men were statistically nonsignificant ($p>0.05$).
Difference statistically significant ①②③<0.0001

No statistically significant differences in frequencies of changes were observed in global symptom intensity before treatment in women and men (Table 3). Similarly, there were no changes connected with gender of future patients as is shown in Table 4, describing changes in global symptom intensity estimated and categorised with the use of coefficient XO.

Table 4

Change in the global symptom level (OWK) during the waiting period, change assessed with XO coefficient

Gender	Major mprovement XO>0.0999	Minor improvement 0.0099<XO<0.0999	No change -0.0099<XO<0.0099	Minor deterioration -0.0999<XO<-0.0099	Major deterioration XO<-0.0999	Together
Women	① 82 – 5%	④ 477 – 27%	870 – 49%	④ 320 – 18%	① 28 – 2%	1777 – 100%
Men	② 38 – 5%	⑤ 222 – 27%	384 – 47%	⑤ 151 – 19%	② 17 – 2%	812 – 100%
Total	③ 120 – 5%	⑥ 699 – 27%	1254 – 48%	⑥ 471 – 18%	③ 45 – 2%	Total 2589

All differences between groups of women and men were statistically nonsignificant ($p>0.05$).
Difference statistically significant ①③④⑤⑥<0.0001 ②<0.001

Incidence of any changes in global symptom intensity (OWK) was observed in 52% of the waiting for therapy group, however there were mostly only minor improvements (27%) or - significantly less frequently – minor deteriorations (18% of the waiting group). Major improvements were also significantly more frequent than major deteriorations (5% vs. 2%, Table 4). There were significantly more cases of frequent improvements (in total; 32%) than deteriorations (in total; 20%, $p<0.0001$), however most frequent were the cases of non-changed symptom levels (i.e. OWK) (48%, $p<0.0001$). There were no differences connected to gender.

In the domain of particular single symptoms constituting global intensity level, very numerous and various changes were observed. Only in 45 patients (i.e. 1.7%) there were no changes in occurrence and intensity of 10 (selected) most frequent symptoms

(lowered mood, feeling exhausted after awakening, feeling tense, intense unpleasant experiencing of events, lack of self-confidence, loss of self-trust, uneasiness, problems with concentration, tiredness, stage-fright, feeling insecure before events, meetings). In 2589 of patients, there were as many as 2296 unique combinations of changes observed – different for each of those 2296 ill persons. With the increase of the number of symptoms analysed, also the increase of number of those unique combinations of changes were observed. In the remaining 248 patients 89 different combinations of changes on occurrence and intensity of 10 selected symptoms were observed - in groups from 2 to 9 patients. With the increase of number of symptoms analysed also the increase of number of those unique combinations of changes were observed.

At the next stage of analysis, which focused on changes of occurrence and intensity of all the 135 single symptoms (however without discrimination, whichever particular symptom was considered) rates of phenomena of a particular sort were calculated for every patient separately. For instance, a description of OWK changes and the changes of occurrence and intensity of symptoms constituting them for three subjects is presented below.

In patient Nr 1245, during her first visit, the global symptom level (OWK) was 508 points, and on the day of admission to treatment 561 points, then during the period of waiting for treatment the global symptom level increased only insignificantly (in categorisation based on XO coefficient there was no significant change). The patient reported in both measurements occurrence of 105 symptoms in total (78% of checklist items), and in the second measurement 20 new symptoms appeared (19% of 105 total complaints), 9 symptoms disappeared (9%), in a dozen symptoms (11%) an increase was reported, in ten (10%) decrease of intensity, and finally in 54 symptoms (51%) no change was reported — neither in intensity nor in incidence.

The second patient, male (Nr 2285), with a global intensity level (OWK) in the first measurement at the initial visit 316 points, and on the day of admission to the day-hospital only 134 points, gained only just by waiting for therapy (lasting in his case 12 weeks) a change in global intensity of symptoms from the range typical for persons suffering from neurotic disorders to the range typical for healthy population (size of change was categorised as “major improvement”). On the admission day, his global symptom level (OWK) decreased by 58% when compared to the first visit. In both measurements during the waiting for treatment, occurrence of a total 71 symptoms (53% of checklist items) were reported, and in the second measurement seven symptoms appeared (10% of 71 reported complaints), 39 symptoms disappeared (55%), intensity of one (1%) increased, while of 21 (30%) decreased, and only three symptoms did not change their intensity or occurrence.

In patient Nr 3119 the value of OWK (global symptom level) on the day of the first visit in ambulatory clinic, was 101 points, and after 2 weeks of waiting, on the day of admission to the day-hospital, it was 388 points. Although the first measurement by the use of the checklist did (statistically) not confirm the presence of neurotic disorder, results of clinical psychiatric examinations indicated its presence. That change was categorised as “major deterioration” – when comparing the two measurements, global symptom level (OWK) increased largely: by 284%. In both measurements there were totally 73 symptoms (54% of items of checklist) reported, as many as 48 new complaints appeared (66% of 73 present in both measurements), 5 symptoms disappeared

Table 5

Changes in symptom intensity during the waiting period – global symptom level (OWK), change assessed with XO coefficient

			Global intensity of symptoms during waiting period:				
			major improvement XO>0.0999	minor improvement 0.0099<XO<0.0999	no change -0.0099<XO<0.0099	minor deterioration -0.0999<XO<-0.0099	major deterioration XO<-0.0999
Women							
Symptom occurrence – total including:		M±SD Me(Q1, Q3)	63%±14% 62%(53%, 73%)	64%±15% 64%(53%, 75%)	68%±15% 68%(56%, 79%)	69%±14% 70%(59%, 80%)	70%±14% 69%(62%, 82%)
change in set of symptoms	symptom appeared	M±SD Me(Q1, Q3)	① 6%±4% 5%(3%, 8%)	③ 11%±6% 10%(6%, 14%)	④ 16%±8% 15%(11%, 22%)	⑤ 29%±9% 29%(23%, 36%)	⑥ 50%±12% 49%(41%, 57%)
	symptom disappeared	M±SD Me(Q1, Q3)	② 54%±14% 52%(44%, 60%)	❶ 30%±10% 29%(22%, 37%)	❷ 15%±8% 15%(9%, 20%)	9%±6% 8%(5%, 13%)	❸ 5%±4% 4%(3%, 7%)
constant set of symptoms	increase of intensity	M±SD Me(Q1, Q3)	① 2%±2% 1%(0%, 3%)	③ 6%±5% 6%(3%, 9%)	④ 13%±7% 13%(8%, 18%)	⑤ 22%±10% 21%(14%, 27%)	⑥ 26%±11% 26%(18%, 34%)
	decrease of intensity	M±SD Me(Q1, Q3)	② 27%±12% 27%(19%, 36%)	❶ 26%±11% 25%(18%, 34%)	❷ 17%±8% 16%(12%, 21%)	9%±6% 8%(4%, 12%)	❸ 3%±4% 2%(0%, 4%)
	constant intensity of symptom	M±SD Me(Q1, Q3)	12%±6% 12%(7%, 16%)	27%±10% 26%(19%, 34%)	39%±16% 37%(29%, 46%)	31%±10% 31%(24%, 38%)	15%±8% 15%(11%, 20%)
Men							
Symptom occurrence – total including:		M±SD Me(Q1, Q3)	61%±17% 59%(44%, 73%)	61%±15% 59%(50%, 71%)	64%±17% 63%(50%, 77%)	65%±16% 66%(52%, 76%)	67%±18% 71%(54%, 81%)
change in set of symptoms	symptom appeared	M±SD Me(Q1, Q3)	❹ 5%±4% 4%(1%, 8%)	⑧ 11%±6% 10%(6%, 14%)	⑨ 17%±8% 17%(12%, 22%)	⑩ 31%±10% 30%(24%, 37%)	⓪ 57%±13% 55%(47%, 66%)
	symptom disappeared	M±SD Me(Q1, Q3)	⑦ 59%±15% 60%(47%, 67%)	❺ 31%±12% 30%(22%, 38%)	16%±8% 15%(10%, 22%)	8%±6% 7%(4%, 11%)	❻ 5%±4% 3%(2%, 7%)
constant set of symptoms	increase of intensity	M±SD Me(Q1, Q3)	❹ 2%±2% 2%(0%, 3%)	⑧ 5%±5% 5%(2%, 9%)	⑨ 12%±7% 11%(6%, 16%)	⑩ 19%±10% 18%(11%, 25%)	⓪ 18%±11% 16%(10%, 26%)
	decrease of intensity	M±SD Me(Q1, Q3)	⑦ 22%±11% 20%(13%, 31%)	❺ 25%±11% 26%(17%, 33%)	16%±8% 16%(10%, 20%)	9%±6% 8%(4%, 12%)	❻ 2%±3% 1%(0%, 4%)
	constant intensity of symptom	M±SD Me(Q1, Q3)	12%±7% 11%(8%, 17%)	28%±10% 27%(20%, 34%)	39%±14% 39%(31%, 46%)	32%±11% 31%(24%, 39%)	18%±11% 22%(13%, 24%)

M – mean, SD –standard deviation, Me – median, Q1 – lower quartile, Q3 – upper quartile.
Statistically significant difference ①②③④⑤⑥⑦⑧⑨⑩⓪<0.0001 ❶❷❹❺<0.005 ❸<0.01 ❻<0.05

(7%), fifteen (21%) increased intensity, while no symptom of decreased intensity was reported, and for 5 symptoms (7%) no change was observed.

Table 5 illustrates the relation of global symptom level (OWK) during the waiting for treatment period with changes of occurrence and intensity of separate 135 symptoms. There is information on rates of intensity changes for symptoms reported in both measurements – "constant set of symptoms", and rates of changes in occurrence of symptoms – disappearing or appearing ("change in set of symptoms").

As shown in Table 5, even in case of lack of significant changes in global symptom level (OWK) in two subsequent measurements, there was an average 16-17% of new symptoms appearing and disappearing (withdrawal) of – similarly – average 15-16% of symptoms that were reported in the first checklist. The number of symptoms decreasing (16-17%) and increasing their intensity (12-13%) was similar. Intensity of circa 40% of the reported symptoms did not change (similarly in women and men).

The frequency of disappearance of symptoms was significantly larger than frequency of decreases of intensity and their appearance was significantly more frequent than increase of intensity (Table 5).

Table 6

Time of waiting for treatment and its relation to global symptom level (OWK) changes

		major improvement XO>0.0999	minor improvement 0.0099<XO<0.0999	no change -0.0099<XO<0.0099	minor deterioration -0.0999<XO<-0.0099	major deterioration XO<-0.0999
women (n=1605)						
Time of waiting (weeks)	M±SD Me(Q1, Q3)	15±12 12(7, 19)	① 16±15 12(6, 19)	②❶ 14±13 10(6, 17)	③❶ 16±13 13(7, 21)	14±12 13(7, 19)
men (n=722)						
Time of waiting (weeks)	M±SD Me(Q1, Q3)	13±10 10(6, 19)	① 11±12 7(4, 13)	②❷ 11±11 7(3, 14)	③❷ 12±10 10(5, 18)	11±8 10(5, 15)

M – mean, SD –standard deviation, Me – median, Q1 – lower quartile, Q3 – upper quartile.

Data for 2327 patients (90% of the group), for whom length of time between filling checklists was estimated.

Statistically significant difference between women and men ①<0.0005 ②<0.0001 ③<0.05.

❶❷<0.05 – only significant differences between groups of results during waiting period in context of time.

Data shown in Table 6, suggest a slight tendency toward smaller changes in global symptom level in situations of shorter waiting for treatment, however such single difference may be considered insignificant (both in women and in men).

Also correlation analyses (Table 7) indicate lack of significant connection (very low correlation coefficients) between time of waiting and OWK (global symptom level) as well as between frequency of changes in occurrence and intensity of particular symptoms (in groups of women and men).

In the analysed group of patients waiting for treatment, the change in global symptom level was observed relatively frequently – average in ca. 50% of the waiting group. Assessment of changes of symptom intensity categorised according to

Table 7

Relation of time of waiting and changes in intensity and occurrence of symptoms

		Linear correlation coefficient	Significance
Women			
change of global symptom level (OWK)		0.02	ns
Symptom occurrence – total including:		-0.01	ns
change in set of symptoms	symptom appeared	0.06	0.05
	symptom disappeared	0.01	ns
constant set of symptoms	increase of intensity	0.02	ns
	decrease of intensity	0.04	ns
	constant intensity of symptom	-0.09	0.05
Men			
change of global symptom level (OWK)		0.04	ns
Symptom occurrence – total including:		0.03	ns
change in set of symptoms	symptom appeared	0.01	ns
	symptom disappeared	-0.03	ns
constant set of symptoms	increase of intensity	0.11	0.05
	decrease of intensity	0.03	ns
	constant intensity of symptom	-0.07	ns

Data for 2327 patients (90% of the group), for whom length of time between filling checklists was estimated.

coefficient XO (therapy results) proved that generally they were minor changes: 27% of minor improvements and 18% of minor deteriorations. Major changes of global symptom level (OWK) during the waiting period were very infrequent (7%), and a bit more major improvements (5%) than deteriorations were observed (2%) (see Table 4). Major improvements of patients' health status during the waiting period were more frequently connected with single symptoms withdrawals (54-59%) than decreases in their intensity (22%-27%, Table 5).

Despite the fact that in 8% of patients global symptom level (OWK) decreased from the range typical for the ill population (above the cut-off point: 200 points for women and above 165 points for men) to the range typical for healthy population (Table 2), they started treatment at the day-hospital (presence of disorder was obviously confirmed by direct clinical psychiatric examinations), and that suggests not experiencing that improvement by patients as "spontaneous remission" (similarly: improvement in 32% of patients "was not an obstacle" in their final will to be treated and admission to therapy).

Percents shown in Table 5 consisted of changes in occurrence and intensity of various symptoms, different in every patient – as one can infer from a separate analysis

(omitted in this paper) performed for all 135 symptoms. It became a reason of limitation of this analysis to the domain of changes expressed by rates of symptoms observed as appearing, disappearing, symptoms of increasing or decreasing intensity, without differentiation which symptom did (or did not) change and which kind of change it was in each member of the studied group.

The presented results show a surprisingly high frequency of appearing and disappearing symptoms, significantly higher than the frequency of symptoms' increases and decreases (transformations of symptom picture of disorders were very frequent).

The changes observed, despite very large differences in time (Tables 6 and 7) – proved not to be connected with the length of time between measurements (duration of the period of waiting for treatment). Significantly a shorter waiting period of men (Tables 2 and 6) seems to be connected with attempts of attaining higher balance in proportion of males and females in therapy groups and acceleration of males' admission for treatment.

Discussion

Changes of global symptom level in neurotic disorders (described hereby as changes of OWK value) are a relatively frequent phenomenon [9] during the period of waiting for treatment (as one can infer from literature quoted - only improvements were as frequent as 30-40%). In this study independently of time of waiting for the treatment period, improvements were found in 32%, deteriorations in 20%, i.e. circa in half of the persons from the "waiting list".

Most frequently observed minor decreases of global symptom level (OWK), may be signs of "spontaneous improvement" related for instance to hope for cure [e.g. 10], or some beneficial change in life condition of patients. Majority of global symptom level decreases was probably a result of the "placebo effect" observed – as it is well known – both before treatment and during its initial weeks [e.g. 1, 4, 10, 11, 28, 29, 30, 31]. It is of course difficult to prove whether such "spontaneous" improvements were only temporary (because all subjects started psycotherapy), but that may be assumed so according to literature [e.g. 4].

Increase of symptom intensity in as many as 20% of waiting for treatment subjects, and lack of improvement in further ca. 50%, suggests that relatively few patients benefit from the unspecific curative factors provided by diagnostic contacts and waiting for the beginning of therapy. For circa 70% of subjects, those factors seem to be meaningless and in 20% do not contain symptom increase, that is frequently explained in literature as resulting from, among others, evoking – during the diagnostic procedure – conflicts, emotional traumas, experiences of negative balance of life etc. [7, 29, 32, 33, 34, 35, 36].

Analysis of proportions in general symptom level changes (OWK) depending on their size (categorised according to coefficient XO) let one indicate an important difference between – assessed in the same way – therapy results, often being "major symptom improvement" [e.g. 9, 27], and size of "spontaneous" changes described in this paper, usually being "minor improvements". Major improvements were observed

only in very few subjects (5%; or more rarely deteriorations, 2%), in majority of the subjects global symptom level (OWK) changed only a bit – with minor improvement (27%) or minor deterioration (18%), while as a result of psychotherapy major symptom improvement can be observed (on average) in ca. 45% patients and minor improvement in ca. 25%, no change was found in ca. 10%, health status of ca. 5% worsened and treatment was dropped by ca. 15% of patients (unpublished analysis of treatment results of 4437 patients).

Most interesting result of this study is the observation of high variability of symptoms set i.e. "syndrome" even in those patients whose changes of particular single symptoms combine (sum) a constant or almost constant global symptom level (OWK). Perhaps in the period of waiting for treatment it is not only neurotic syndrome intensity that changes, but also experiencing of the future patient, responsible for presence of the disorder. Then the question arises - to what extent results of ambulatory examinations (selection for treatment) and initial psychopathological conceptualisations – based on the first picture of the ill person, changing in the course of time (e.g. under influence of various stimuli generated during detailed initial examinations) – are still valid in the moment of admission for psychotherapy.

Increase of some and decrease of different symptoms and even "symptom exchange" are phenomena coherent with the structural theory of neurotic disorders by J. W. Aleksandrowicz [37, 38, 39], explaining such a variability of psychopathologic picture by systemic transformation processes of a specific "neurotic symptoms language". This is why it seems that despite such large changes in the symptom picture, one can consider a psychopathologic picture of a patient as constant in its variability (and independent from length of waiting for treatment, at least in the analysed period i.e. from a few weeks to some dozens of weeks) and the diagnostic examinations conducted on the beginning of that waiting period may be considered to be reliable enough.

In the analysed years length of waiting for treatment for half of the patients did not exceed 3 months, for 83% it was shorter than half a year and only for 3% it was longer than a year. Despite the fact that explanation of such large differences requires separate analyses, it now seems that among some important reasons there are differences of availability of treatment in some years, type of disorder and, in the aspect of way and mode of admission for treatment, attempts to attain a more balanced proportion of women and men in the therapy groups (responsible for shorter waiting time for men).

In the studied group the differences in time of waiting for treatment did not affect the presented results of analyses of symptom dynamics but one may suspect the influence of other factors e.g. contacts with mental health specialists referring for treatment which were obligatory for many years, varying ways of informing patients about the purposes and rules of therapy etc. Because of large time flow (years 1985-2002) analysis of those factors was impossible. It was not possible to obtain data regarding potential treatment of patients during the period of waiting for admission to other clinics (e.g. family doctors), drug use, e.g. homeopathic medicine etc. Perhaps such information could contribute to a better understanding and explanation of the context of occurrence in the period of waiting for treatment, cases of symptom improvements, especially major ones.

Conclusions

1. In the analysed group of patients waiting for treatment, a change in global symptom level was observed in circa 50% of subjects.
2. Global symptom level decrease was more frequent than the analogical increase.
3. No differences connected to gender of patients were observed, what contradicts a common view on higher variability of symptoms in women.
4. There were no significant relationships between global symptom level changes and kind of changes in intensity or occurrence of particular single symptoms, with duration of the period of waiting for treatment, which typically did not exceed half a year and was significantly longer for women.
5. Performed analyses showed that during the waiting for treatment period transformations of the neurotic disorder picture (set of symptoms, syndrome) were frequent, resulting even in improvement (even "major") or deterioration in the domain of global symptom level. Transformations were composed of both appearances as well as disappearances of particular single symptoms and changes of their intensity.

Importance of the observed changes and factors influencing their emergence and effects, being symptom improvement or deterioration, especially in the aspect of their relation with final psychotherapy results require further analyses.

DECLARATION OF INTEREST: Research was not sponsored.

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