Archives of Psychiatry and Psychotherapy, 2015; 4: 77–99

DOI: 10.12740/APP/61033

Reflection on the possibility of alternative approach to the psychopathology of "functional" disorders

Jerzy W. Aleksandrowicz

Summary

Functional short-term disorders provoked by extremely difficult life events are entirely different from the chronic or recurrent ones: anxiety or other "neurotic" syndromes, eating, sexual and some other disorders, not being conditioned behavioral dysfunctions. Chronic/ recurrent disorders seem to have they causes in particular personality traits and deficits. Some of them are revealed, described and could be measured by means of Neurotic Personality Questionnaire KON 2006. In this approach, functional disorder is understood as a structured systems of the particular nonverbal language ("parole") in which symptoms play a role of words while syndromes the role of sentences, expressing the current state of mind – mainly the need of bond with other people and its frustration. They are messages of looking attention, attachment. The use of such language seems to be the result of personality deficits making difficult or even impossible to fulfil the need of bond in the psychosocial field using common for done culture verbal and nonverbal language, "normal" means of communication. While in the acute and conditioned reactions on stress different forms of helping people (e.g. CBT) seems to be adequate, in the chronic and recurrent functional disorders therapy is postulated to aiming rather at transformations of the communication, leading to the exchange of the messages' language having the quality of disorder for common, mainly verbal one.

functional disorders /psychopathology/communication

Some doubtful paradigms of contemporary psychopathology of functional disorders

The psychopathology and classification of mental health dysfunctions is based on the "phenomenological approach", understood as the description of visible phenomena, mainly symptoms. Groups of symptoms that are more or less distinguished from others and observed repeatedly (at least to some extent) are considered "disorders" or "diseases" and become elements of classification systems. Where borders between such classes are unclear, serious difficulties arise in the diagnostic tasks and from time to time initiatives are called forth to reconstruct them and to "discover" new items ("independent disorders"). This creates an impression of progress of science, being as a matter of fact only an attempt at introducing another, also artificial, order in the chaotic pool of data.

It is also problematic that classification systems seem to be subordinated to the rules of administrative tendency for grouping no more than 10 elements in one wide category. For this reason, if there are more than 10 similar "disorders", some are arbitrarily placed into a separate category. This rule proved more important in the differentiation of an independent category

Jerzy W. Aleksandrowicz: Department of Psychotherapy, Jagiellonian University Medical College, Krakow, Poland
Correspondence address: mzaleksa@cyf-kr.edu.pl

named "behavioural disorders" than the eventual differences in psychopathology. The existing mental health problems' classification systems – the DSM [1] and the ICD [2] – as well as the psychopathology of disorders in general are commonly considered inadequate for the diagnostic and therapeutic purposes, particularly with regard to "functional" disorders. This inadequacy of classification of the real patients' symptom manifestation forces practitioners to use mainly such diagnostic categories as "not otherwise specified", "mixed", "unspecified" or to apply the concept of comorbidity. The problems with classification of functional disorders are partially connected with their "functional" specificity. A disorder is considered "functional" because it is not directly provoked by some concrete, covert damages like, for instance, in infectious illnesses. For this reason, it is unclear how to decide what these "functional" syndromes express. Moreover, they are extremely differentiated and every symptom could be present in any functional syndrome [3].

All efforts undertaken from years, aiming at the construction of a reliable classification system of functional disorders have been unsuccessful so far and were more or less artificial. However, also the contemporary state of knowledge does not offer really better solutions.

It also needs to be considered that the etiopsychopathology of all mental disorders, especially of the "functional" type, seems to be based on some questionable paradigms. First of all, their psychopathology is considered mainly as a simple opposition to "normality" and a disorder is understood as an adversity of a "proper" functioning of a person. As a consequence, theories concerning these disorders are constructed rather as an opposition to psychological assumptions concerning "normality", "healthy" functioning of a person and his/her development, than by exploring the specificity of disorder. This way of reasoning seems to be outwardly logical. However, it neglects the qualitative differences between health and illness, even giving up efforts to define them. Regrettably, it is grounded, among others, in the World Health Organization's (WHO's) definition of health as "well-being". Consequently, one persons' state of health is understood as a given point on the "quantitative continuity" between health and illness, and this contributes to the difficulties in understanding the etiopsychopathology of functional disorders.

Owing to such paradigms, functional disorders are considered to lie on the border of illness and normal functioning and to be psychological rather than medical problems. This leads to obscuring the difference between disorders and "psychophysiological" reactions. Such an approach is supported by an extreme similarity of those dysfunctions to the symptoms of functional disorders. This seems also to be one of the factors reinforcing tendency to neglect evident illnesses and to present ill persons – patients – as healthy "clients". This vagueness also seems to be the main reason for an opposite tendency: to consider some non-medical reasons of human suffering as illnesses, and consequently to seek medical help and pharmacological treatment.

The lack of clear difference between the quality of disease and the quality of mental health is even more harmful for the psychopathology of psychotic and affective disorders. The most evident example is the apparent excessive enlargement in the past decades of the concept of affective disorders, medicalizing most of the phenomena of natural sadness. Not neglecting different economic and social benefits of this vagueness, it may be dangerous for the patients and for the progress of science. The old-fashioned, "medical", qualitative model of illness understood as a unit and including, *inter alia*, material causes and a definite damage, is evidently insufficient for explaining mental health problems. Replacing the concept of illness with the concept of disorder does not offer, however, a real opportunity to overcome the limits of the traditional, reductionist approach. Moreover, a set of symptoms – syndrome – is frequently treated as a "provisory" sign of the existence of some covert physical damage, prompting a search for symptoms' causes, for instance through neuroscience tests.

It is evident that research of the neurophysiological correlates of psychic functions, especially neuroimaging procedures, opens new opportunities for understanding the functioning of the mind. Results informing of brain processes are very important also for psychopathology [4, 5]. Confirmation of the hypothesis concerning the reciprocal influences of the mental

state and the brain functions is essential. However, neuroscientific data (including neuroimaging investigations) should be approached with limited trust due to their questionable relevance to symptom-based illness categories [6]. On the other hand, considering the fact that symptoms are mainly subjectively experienced phenomena, syndromes cannot be the real basis for such research, not even in theory. Such research, combining the intensity of local brain activity with the presence of disorders, produces "side-effects" – the reinforcement of the biological model, suggesting the possibility of psychopharmacological treatment.

Of equally limited use in psychiatric practice is the biopsychosocial holistic model. A "multidimensional" description of illness appears theoretically justified. In practice, however, it does not offer instrumentally useful indices for the classification of different variants of psychopathology and for diagnosis of a particular person (although it is helpful in the description of the circumstances of their illness). In therapy also: the complex, multidirectional therapeutic activities frequently seem to be hardly justified and even unnecessary. It may be more practical to choose from the different circumstances of pathology, its scope being the most important, and to make it the crucial target of treatment. On the other hand, there are aspects of complex etiopathology (e.g. genetic ones) that are still nowadays beyond the influence of corrective interventions.

The lack of scientific and epistemologically well-grounded basic paradigms [7, 8] for research is one of the important difficulties in constructing an appropriate model of the psychopathology of functional disorders. This is the reason for the formation and general acceptance of different doubtful theoretical assumptions.

For instance, the concept of "psychogenesis" is currently reduced practically to a reaction to everyday life stressors. On the level of symptoms, and thus also in terms of symptomatology, the difference between chronic or recurrent functional disorders and short-term reactions is infinitesimal. As a result, the etiological difference between stress reactions or adaptive disorders and "neurotic disorders" has also vanished. This seems to be unjustified from theoretical as well as practical point of view. Another paradigm which creates difficulties in the formation of a reliable psychopathology are psychoanalytical concepts reducing the etiopathology of mental illness to the impact of early childhood developmental processes, simplifying and covering the diversity of real circumstances responsible for a given disorders.

Unreliable diagnostic rules

Another set of problems associated with the "symptom-oriented" classification of functional disorders is related to diagnostic procedures. "Objective" instruments (like symptom checklists or questionnaires measuring defence mechanisms) are not very reliable for assessing the type of disorder. On the other hand, diagnosis is generally a subjective process, depending on the therapist's cognitive schemas and theoretical assumptions. Moreover, the effects of diagnostic procedures seem to depend on the patient–diagnostician relationship and on the patient's/client's expectations concerning what might be most important for the therapist, not only on the type of disorder diagnosed [9]. This is one of the reasons why the diagnosis (in fact, a description of a syndrome) seems to be accurate only at the moment of the diagnostic interview. Additionally, serious difficulties for a reliable diagnosing process are created by symptom instability [10, 11]. For all those reasons, one might be diagnosed as having dissociative, obsessive–compulsive or even a personality disorder in a given day.

The phenomenon of changes in an individual's syndrome, occurring even in a very short time, is very difficult to explain using current psychopathology. At the same time, functional disorder happens to be treated as a particular, stable, "medical" unit. This sometimes results in diagnostic decision of treating such changes in the clinical picture of recurrent disorder as a manifestation of an onset of a new, different illness, or is assigned to some unclear, perhaps sociocultural factors [8].

The frequency of most of neurotic" symptoms' changes in time, as was indicated in studies of the subsequent groups of treated populations over 20 years [3]. Through centuries, important changes in the symptomatology of functional

disorders have also taken place with some new forms of syndromes apparently arising, while others disappear. We do not have any good answers why, for instance, so-called hysterical symptoms, observed so frequently at the beginning of the 20th century, have almost completely disappeared. Or, why the frequency of neurasthenic or psychastenic syndromes evidently diminished in West European societies, while depressive or eating disorders have become much more frequent. It seems to be not only the issue of relabeling or more precise diagnostic procedures emerging, but first and foremost of the transformation of the clinical picture of functional disorders.

Short-term versus chronic functional disorders

To overcome the above doubts resulting in the chaos of conceptualization of the nature of functional disorders, it seems reasonable to continue the search for alternative approaches. In the proposal presented here, the main step is the differentiation of functional short-term disorders provoked by stressful situations, crisis and/or extremely difficult life events, from chronic or recurrent disorders, being the result of some personality dysfunctions and intrapsychic processes. Those two groups, identical from the symptomatic point of view, are completely different in their etiology. In the first group, the concept of "psychogenesis" understood as a reaction to acute or chronic excessive stress seems to be coherent. Symptoms are mainly connected directly to stressful circumstances, and they generally express fear and tension, the need for help and support. They are also a manifestation of individual mechanisms of coping with severe stress – being most often a type of avoidance behaviour. Perhaps due to the relative simplicity of those reactions, the diversity of the symbolic meaning of symptoms is limited in comparison to chronic functional disorders.

Such "anxiety", "neurotic" or somatoform reactions are not very far from psychophysiological ones. For instance, an overwhelming anxiety reaction to a dangerous traffic accident is very similar (only much more intense) to a student's anxiety before a difficult exam. The existing psychological and physiological concepts may be very useful and seem to be satisfactory in explaining the mechanisms of such reactions. However, stress-provoked reactive disorders differ quantitatively as well as qualitatively from psychophysiological reactions. Perhaps due to their high intensity and limited differentiation of symptoms, the first are commonly considered as illnesses. Psychophysiological reactions, much more connected in their symptomatology to the kind of stress, are mostly treated as reasonable variants of normal behaviour.

The second group of functional disorders are chronic and/or recurrent disorders such as anxiety or other "neurotic" and behavioural syndromes that are not simply situation-conditioned in a previously undisturbed person. They seem to have their source in particular personality traits and deficits and are rather stable phenomena, mostly resulting from social learning in the early stages of life or some major life events in adulthood. Of course, some traumatic circumstances may be personality-disturbing factors in every moment of a person's life – like in the case of post-traumatic stress disorder (PTSD).

To treat a given, popular symptoms' configuration as a disorder seems to be unjustified. Detailed investigations using symptom check-lists such as SCL-O (see Appendix 3) have revealed, that in every case of a chronic/recurrent functional disorder symptoms considered as specific to another disorder can also be found [3]. So it seems that it is more reasonable to treat all of them as one complex type of illness. The observed differences between syndromes seem to be secondary and temporary. Perhaps some of them could also be the apparent result of the already mentioned specificity of diagnostic procedures.

The presence of personality factors in the course of functional diseases had been forecast for many years and most of the psychological questionnaires contain the dimension of "neuroticism" (Eysenck's Personality Theory – EPT), "neurotic tension" (16 PF-The Sixteen Personality Factor Questionnaire, scales of MMPI-2-Minnesota Multiphasic Personality Inventory) [12], "trait-anxiety" (The State-Trait Anxiety Inventory-STAI) [13], etc. However, the respective scales are constructed from items concerning the presence of symptoms. So, the concept of "neuroticism" is there simply an extrapolation of the

presence of symptoms and not a direct information about the existence of some particular "neurotic" personality.

From the point of view of clinical experience it seems more than probable that such particularity of a "neurotic personality" exists. This personality inefficiency probably consists of a particular constellation of specific personality traits, including also deficits, inappropriate cognitive schemas etc. It is probably the main reason for the formation of different intrapsychic dysfunctions, like unconscious conflicts, causing the person suffering, ineffective functioning and helplessness.

Particular personality traits and deficits, being supposedly the ground for chronic functional disorders, are usually covert and only sometimes are some elements observable in the clinical picture. Thus they are a marginal part of the syndrome, in contrast to "specific" personality disorders. But frequently this creates an illusion of the presence of some personality disorder and so such patients are diagnosed with it, and not with for instance one of the anxiety disorders.

Towards describing and measuring neurotic personality factors

Even though this is a very difficult task, it seems possible to distinguish those particular personality factors. Some are revealed, described and can be measured by the Neurotic Personality Questionnaire [14-17]. But more useful than values in particular scales of this questionnaire appears to be the global value (X-KON) indicating the presence (or absence) of neurotic personality. The presence of such a set of traits and deficits can be confirmed if X-KON coefficient exceeds 18 points. Higher values were observed in more than 80% of the evaluated population of persons treated in the department of neurotic disorders (mean 46.9 +/ – 17.6 points), while in more than 80% of the control group the value was below 8 points (mean 1.8 +/ – 1.9 points). Some of the 24 scales distinguished by taxonomic calculations inform about the character of particular traits and/or personality deficits. (Questionnaire items are presented in the Appendix 1). Their configuration reveals individual structure of personality (see Appendix 2).

But what is most important is the opportunity to distinguish, on the basis of the X-KON value, the difference between functional disorders arising as a reaction to stress (in such cases X-KON is lower than 18 points) and personality grounded, chronic functional disorders. This value also permits to differentiate this personality dysfunction from "specific personality disorders".

This questionnaire, describing and measuring various traits and deficits is suspected to be responsible for functional disorders, is however lacking a scale to reveal directly the most important clinically observed deficit: the underdevelopment of a capacity to express needs to gain the attention of another person, to build and sustain a bond. This deficit is claimed, for many reasons – theoretical as well as clinical – to be the main personality factor responsible for the formation of functional symptoms.

The necessary condition to fulfil these needs is to send a message provoking other people to react. Limited opportunities to formulate such a message in the common verbal and nonverbal language seem to be one of the main factors in the etiology of functional disorders.

Bond is necessary for every person's existence and its role is largely recognized by psychology describing "healthy" mental functioning as well as by the psychopathology. Bowlby's attachment theory is a good example [18, 19]. But in the development and functioning of a human being no less important than the emotional aspects of the relationship with parents and other attachment figures are cognitive and linguistic processes, enabling to receive attachment.

Language is not only a condition of the formation of psyche and consciousness (Chomsky, [20]) but also the optimal way to create a bond with other people, using verbal and nonverbal means of communication specific to the culture the person belongs to. It is necessary to formulate messages that others can understand. An opportunity to express such message in a common language depends on the consciousness processes. The need of the bond should be put into concepts, being the basis of words, and afterwards could be externalized, openly addressed to other person. Usually, such a message formulated in terms of a common language offers reciprocal attention, interest, friendship, love, etc.

These processes of bond and attachment creation may be described in terms of Levin's theory[1] [21, 22] as formation of a network of vectors stretching between the subject and other individuals, who actually or at least potentially may be able to satisfy these needs. They may be real, emotionally important persons existing in the objectified environment, but they may also be imagined or, for instance, inaccessible idols. Thus, this field has two levels – the real and fictional one[2].

In the case of the impossibility of pushing on conscious processes due to a lack of necessary personality and interpersonal skills (e.g. in the case of alexithymia) or some external factors (e.g. imprisonment in isolation), a person is doomed to loneliness, to the deprivation of such fundamental, existential need of attachment. Being unable to solve his/her problems and inner conflicts caused by this lack of bond, they are helpless. The deficit itself as well as its consequences, e.g. the conflicts they provoke, are mostly unconscious.

Facing a lack of an opportunity to fulfil these basic needs, a person is forced to search for ways to cope. Apparently, this is relatively easy, as most cultures offer some possibility of overcoming such incapacity. A person's somatic illness causes their social environment to offer them (at least temporarily and even in some artificial, task-oriented way, during treatment) some attention, care and support. The common experience of such social behaviour is the reason for using functional symptoms, recognized by other people as illness or disorder, for sending them a message expressing the need for attachment and for receiving their attention and care.

Functional disorders as a form of communication

The proposed approach to the psychopathology of functional disorders treats them as a means of communication, expressing in nonverbal, individual *parole* the content of current psychic processes, a person's state of mind [22, 23]. Thus, functional disorders are considered to be a particular form of nonverbal language in which symptoms takes the place of words and syndromes – of sentences. Like every other "significant", symptoms and syndromes are integrally connected with the "signifiee's", in this case – covert, frequently unconscious – psychic state [23].

This language is used with the aim of sharing with other persons the subject's state of mind and fulfilling their need for presence and attachment. A functional dysfunctions syndrome may be treated as such particular nonverbal language for sending messages to other – actually present or fully imagined – persons. Generally speaking, as an expression of desire (in Jacques Lacan's terms) [24]. But the price of such a solution is additional suffering, provoked by the functional disorder itself.

Structural linguistics offers an opportunity to understand different clinically observed phenomena, characteristic for functional symptoms and disorders. Treating them as a particular nonverbal language is to expect that the functional syndrome of one person has a character of a structured system in the meaning described by (among others) Jean Piaget[3] [25]. The structure of

[1] Kurt Lewin's "field" theory concerning the functioning of the individual in social settings.

[2] The difference seems not so great considering that the person contacts only an image of the perceived object, constructed in his/her mind.

[3] In Piaget's description:

a. Structure is a unity, "Gestalt", whose elements obtain new characteristics they do not possess out with this unity. Some relations of elements create a context in which a singular element – e.g. the disturbance of a function – acquires a new quality it would not have apart from this unity.
b. This unity exists and obtains its coherence owing to the processes of continuous transformations and their dynamics. These processes function according to the laws of transformation.
c. The structure is self-regulating, which denotes a limitation of the scope of transformations that are not capable of going beyond what makes them bound and coherent. Transformations take place internally. The range of those preserving-like transformations is delimited by the transformation laws which constitute the structure.
Transformation laws determine whether the structure possesses greater or lesser power. This fact is bound with the grade of generality of the structure. Weak, temporal, feedback regulated or symmetrically steered structures are themselves elements of strong, more general and solid structures – which are regulated by reversible operations [22]. In this meaning, a "systemic approach" has a much more general sense that in family therapy named "systemic", reducing concepts of system and structure to relations in the family.

such a system is sustained by transformations of symptoms forming the syndrome.

Up to the concept of systems' hierarchy, if communication in general can be viewed as the "strongly" structured system of activity, the different forms or communication styles should be treated as "weak" ones, as subsystems (substructures), replaceable elements of this general system. Functional disorders, being one of such forms, differ from others by having the quality of "disease". This may open an opportunity for treatment by a transformation of this subsystem of communication into another one, but not of illness quality. (In terms of structural theory, weakly structured systems, such as syndromes, are steered by feedbacks, e. g. they are reinforced by positive reaction to the messages).

So, functional syndromes can be considered structured messages – a way of a person's functioning in interactions looking for attachment. Their symbolic meaning depends on the psychic state of the subject in a given moment. The content of the message could mainly include different aspects of suffering, provoked by conflicts and weaknesses, by an ineffectiveness of coping with current problems, insolvable by the person for different – intrapsychic as well as external – reasons.

But to communicate successfully by means of symptoms is particularly difficult. From the linguistic point of view, all symptoms are homonyms. Every one of them can express extremely varying contents of psychic processes. This makes it difficult to understand unequivocally their meaning, as much in the ill person's everyday functioning in the psychosocial field as in the diagnostic procedures.

So, it this sense it seems true that functional symptoms have symbolic meaning, like Freud suggested a hundred years ago, taking on the role of being "significant". This quality does not appear when the same distortion is a symptom of e.g. an organic disorder. But this meaning is extremely individualized and differentiated. It depends partly on the specificity of the subculture the person is living in, on the individual language they use – her/his *parole*, in the terms of structural linguistics – but mainly on the kind and context of psychic experiences, being the momentously "signifiee's" of those signs.

It seems important to mention here, that research, using a taxonomic analysis of the symptoms' frequency, reveals their equivalence. Every symptom could be replaced by another one, while a syndrome persists as a structured whole [22, 23]. The exchange of elements of the system is probably a force sustaining its existence, like in the case of every dynamic structure. Nothing strange, that the instability of one person's set of symptoms, frequently interpreted as improvement, could actually be a reinforcement of the disorder. On the other hand however, the variability and instability of symptoms seems to be dependent on changes in temporary contents of the psyche. It is trivial and evident that the current state of mind, expressed by symptoms, is changing from moment to moment, and this is probably the main explanation for clinically observed instability of functional syndromes.

Moreover, not only the unconscious or repressed mental processes, but also the consciously realized reasons for helplessness may be expressed by means of symptoms. This results in a frequently observed insufficiency of insight in the treatment of functional disorders. Often, gaining awareness is not sufficient to cope with the reasons for helplessness.

This way of understanding the etiopatology of functional disorders can also explain the changes of functional syndromes depending on sociocultural conditions. They seem to be the effect of the influence of feedback, present in the field of the subject's interactions with others.

Thus, functional disorders may be understood in terms of communication (communication in the "social" field in Levin's terms, or rather in the "psychosocial" one) with a real or imagined person being the object (partner) of attachment. So it seems, the subject of diagnosis and treatment should be first of all the current incapacity to use the common language for forming a bond and the disturbances in current psychic processes connected with such a difficulty. The use, with the aim of communication, of this particular nonverbal language of different dysfunctions – symptoms, seems to be the result of personality deficits making it difficult or even impossible to fulfil the need of bonding in the psychosocial field using common, "normal" means of communication. As mentioned before, this impairment is not directly revealed or measured

by any one of KON's scales[4], but it seems to be expressed by the global X-KON value.

It is important that the personality factors responsible for the rise of functional disorders seem to be entirely different from the traits of "specific" personality disorders or "predisposition for psychotic illnesses"; as well as other severe personality dysfunctions considered to be independent disorders. Some of the so-called pre-psychotic personalities, similarly to "characteropathy", are mainly the consequence of biological (e.g. metabolic, traumatic) damage, being – akin to symptoms of a somatic illness – external expressions of this damage.

In the case of specific personality disorders (being mainly the result of harmful social learning), basic disturbances of functioning seem not to have a character of symptoms expressing such impairment. Disturbed behaviours and dysfunctions in the mental processes are integrated elements of such personality systems. They are "mature" and strong, however this maturity is distorted in different pathological directions. For this reason they are frequently "ego-syntonic", resistant and not identified by the person (and sometimes even by their social environment, like in the case of artists) as disturbances. In those disorders the aim of therapy is to cope with the disturbed and strongly structured system of personality, and not – like in the case of functional disorders – with the structured system of nonverbal language.

Of course, there is a possibility that such specific personality disorders coexist with neurotic personality traits, responsible for evoking functional disorders. It seems very likely that the harmful conditions of socialization processes could in parallel contribute to the difficulties in expressing the need of a bond and "specifically" distorted structure of personality. The frequency of such comorbidity observed in clinical settings is important. In a group of patients with specific personality disorders different functional symptoms are relatively common, and similarly, in a group of patients with functional disorders some specific personality traits could be present.

The theoretical approach proposed here as an alternative to contemporary psychopathology of functional disorders and their classification offers an opportunity of a cohesive explanation of the different aspects of their etiopathology. First of all, it explains the lack of clear borders between different functional "disorders" [3]. It explains the similarities and differences of psychophysiological disturbances, reactions to stressful life events, adjustment [26] and chronic or recurrent functional disorders, as well as the difference between functional and specific personality disorders. It also explains the role of the relationship between the potential of personality (e.g. richness of coping mechanisms) and normal life difficulties (stressful situations) and the emergence or recurrence of syndromes; the role of adaptation and the triggers of functional disorders, the role of the unconscious in their pathogenesis; the phenomenon of a symbolic function of symptoms as well as of individual variability and instability of symptoms and syndromes. It also refers to the appearance of symptom improvement, like in the case of replacement of somatic symptoms by "problems" or other dysfunctions in the mental processes. It also offers an alternative explanation of the meaning of psychogenesis, which may be understood as a crossroads of personality traits and/or deficits and of the current content of psychic processes being a reflection of life events. Even using a sociolinguistic – i.e. humanistic and not biological – model to explain functional disorders places them on the side of illnesses, of medical issues, and not on the side of common, normal behaviour or existential problems.

The presented approach also offers an alternative view of understanding psychotherapy and some of its effects, for instance the role of relationships. The therapeutic contact "automatically" offers an opportunity to gain attention and bond, thus fulfilling the needs of the person and making the dramatic creation of a message by means of symptoms superfluous. This is the reason for an apparently curative character of a therapeutic relationship. Tension is diminished and an improvement on the symptomatology level is spectacular, however temporary. But even though a relationship is a necessary condition of treatment, it is a substitute of a cure, and not really a curative factor, and unsurprisingly, frequently provokes dependence on the psychotherapist.

[4] It could be the effect of multiple personality factors being responsible for this impairment.

This approach underlines the importance of the "here and now" state of the psychic processes, especially of the linguistic skills necessary to gain the other person's presence and attention, rather than concentrating the therapy on past experiences or traumas affecting the attachment in childhood.

It seems particularly important to overcome the conviction that the person's early development is the main or even the only cause of distortions of the adult person's mind[5]. Such determinism is a needless heritage of psychoanalysis. Otherwise, current psychology and psychopathology are to a great extent overgeneralization of some observations, gathered by paediatricians and child psychologists, but not really useful for understanding either the psychology or the psychopathology of adults.

So, if in the "conditioned disorders" and/or "psychophysiological reactions" different forms of helping people (e.g. cognitive–behavioural therapy (CBT)) seems to be adequate, they are not sufficiently curative in other functional disorders. In chronic and recurrent ones the therapy should aim at transformations of the structure of language, thus leading to an exchange of one of its substructures for another one. This means transformation of the parole, using symptoms, into parole using words – a disruption of a substructure of the communication system of an illness quality. This is possible, provoking by feedback, to replace the disturbances of functions by words, and to learn (or re-learn) the use of a common language aiming at receiving attention and bond.

Such a therapy should be different from education in some theoretical approaches, being the essence of all therapies that lead to insight interpretations and explanations. Sharing psychological knowledge by the therapist with the patient leads to a replacement of a functional disorders' language with a language of the therapist's theory. Not neglecting the role of the "name" and rationalization as unspecific treating factors, they rarely, and only by chance, are really curative. This proposal is also different from the "transtheoretical" rules of provoking change [27], very useful in "helping" psychotherapy (counselling) but hardly adequate for treating functional disorders.

In every disorder, a reliable therapy must be coherent with its psychopathology. So, a successful psychotherapy of functional disorders is possible only if the concepts concerning their essence and etiology will be more reliable than those currently available. Perhaps the presented approach may be at least a signpost for constructing a more useful theory of the psychopathology of functional disorders.

[5] It is evident that early experiences have a strong influence on the development of the mental structure and they could explain psychopathology formation. This makes evident the preventive functions of education. This does not mean that the past (or its traces) is the most important element of the current state of the disordered psyche.

REFERENCES

1. American Psychiatric Association. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). APA; 2015.
2. World Health Organization. International Classification of Diseases, 10th edition (ICD-10). WHO, 2000.
3. Aleksandrowicz JW. Neurotic symptoms' frequency. Arch Psychiatry Psychotherapy; 2001, 2 (3), 15-26 (Psychiatr. Pol. 2000, 34 [1] 5-20)
4. Fried EI, Tuerlinckx F, Borsboom D. Mental health: more than neurobiology. Nature. 2014; 508: 458.
5. Crossley NA, Scott J, Ellison-Wright I, Mechelli A. Neuroimaging distinction between neurological and psychiatric disorders. Br J Psychiatry. 2015; 207(5): 429–434.
6. Roiser J. What has neuroscience ever done for us? The Psychologist. 2015; 28(4): 284–287.
7. Gelo OCG. On research methods and their philosophical assumptions. Raising the consciousness of researchers, again. Psychotherapie Sozialwissenschaft. 2012; 2: 109.
8. Gelo OCG, Vilei A, Maddux JE, Gennaro A. Psychopathology as social construction: the case of anorexia nervosa. J. Construct Psychology. 2015; 28(2): 105–125.
9. Aleksandrowicz JW. Diagnoza zaburzeń nerwicowych. In: (Ed. J. Paluchowski) Z zagadnień diagnostyki osobowości. Ossolineum 1983, 59-92.
10. Aleksandrowicz JW. Prevalence of neurotic symptoms: a changing pattern. Arch Psychiatry Psychotherapy. 2001; 3(4): 45-69.
11. Mielimąka M, Cyranka K, Rutkowski K, Sobanski JA, Dembińska E, Müldner-Nieckowski Ł, et al. Critical reflection on contemporary diagnostic criteria from the perspective of differentiation and dynamics of symptoms in patients with neurotic disorders and disturbances in personality function-

ing treated with group psychotherapy [conference abstract]. SPR Conference Klagenfurt. 2015.

12. Cyranka K, Rutkowski K, Mielimąka M, Sobański JA, Smiatek-Mazgaj B, Klasa K, et al. Changes in personality functioning as a result of group psychotherapy with elements of individual psychotherapy in persons with neurotic and personality disorders – MMPI-2. Psychiatr Pol. 2015; 25 [published ahead of print].
13. Mielimąka M, Rutkowski K, Cyranka K, Sobański J, Dembinska E, Muldner-Nieckowski Ł. Trait and state anxiety in patients treated with intensive short-term group psychotherapy for neurotic and personality disorders. Psychiatr Pol. 2016; 36 [published ahead of print]. Nr 36
14. Aleksandrowicz JW, Klasa K, Sobański JA, Stolarska D. KON-2006 Neurotic Personality Questionnaire. Arch Psychiatry Psychotherapy. 2009; 1: 21–29.
15. Aleksandrowicz JW, Klasa K, Sobański JA, Stolarska D. Kwestionariusz Osobowości Nerwicowej KON-2006 [Neurotic Personality Questionnaire KON-2006]. Kraków: Biblioteka Psychiatrii Polskiej; 2006.
16. Trabczyński P. 'Personal factors of neurotic disorders (cross cultural analysis) – thesis PhD. St. Petersburg University; 2009.
17. Ježkova V. Diagnosticka hodnota dotaznika KON-2006. Doctors thesis. Masarykova Univ. Bratislava, 2013.
18. Bowlby J. Attachment. Penguin Press: London; 1969.
19. Brown D, Hawkins Rodgers Y, Kapadia K. Multicultural considerations for the application of attachment theory. Am J Psychother. 2008; 62(4): 353–639.
20. Chomsky N. Language and Mind. New York: Harcourt Brace & World, Inc., 1968.
21. Levin K. Resolving Social Conflicts and Field Theory in Social Science. Washington, DC: American Psychological Association; 1946.
22. Aleksandrowicz JW. Neurosis as a dynamic structure of communication in a psychosocial field. Dyn Psychiatry. 1984; 84: 72–84.
23. Aleksandrowicz JW. The "structural-linguistic" theory of neurosis and its therapeutic consequences. Medit J Soc Psychiatry. 1986; 2: 121–125.
24. Lacan J. Ecrits. Editions du Seuil: Paris; 1966.
25. Piaget J. Strukturalizm. PWN: Warszawa; 1972.
26. Casey P, Jabbar F. Adjustment disorder considered. Adv Psychiatr Treat. 2013; 19: 99–107.
27. Prochaska JO, Norcross JC. Systems of Psychotherapy: A Transtheoretical Analysis. Brooks/Cole; 2003.

APPENDIX 1

ITEMS OF NEUROTIC PERSONALITY QUESTIONNAIRE KON-2006

The questionnaire is composed of a set of questions concerning various characteristics, preferences, tendencies, attitudes, views, etc. There are no right or wrong answers, after all, every person is different. Please answer honestly and without longer reflection, especially without considering „how the question should be answered" – the proper diagnosis of a health condition requires that you present yourself as you really are. Only one answer can be given to each question: „yes" or „no". Please choose and indicate the one which seems to be right. If some wording is not clear, and it is difficult to decide, because, for instance, both options seem likely – please consult the person carrying out the examination. Before you finish completing the questionnaire, please check if each question has an answer marked.

0	The instruction on how to complete the questionnaire is clear.	YES	NO
0	Is the instruction on how to complete the questionnaire clear	YES	NO
1	I care about being liked by everyone.	YES	NO
2	I think for a long time before I make a decision.	YES	NO
3	My way of acting is often misunderstood by other people.	YES	NO
4	I often take a risk only for the pleasure of risking.	YES	NO
5	It annoys me when someone is glad.	YES	NO
6	I often do things I am asked for against myself.	YES	NO
7	I always decide myself about what I want to do.	YES	NO
8	It is difficult for me to approach someone I would like to meet.	YES	NO
9	I usually have enough energy when I need it most.	YES	NO
10	People often "walk all over me".	YES	NO
11	There are not many things that give me pleasure.	YES	NO
12	I often cannot present my abilities.	YES	NO
13	I rarely reveal my feelings, even to my friends.	YES	NO
14	I am terribly ugly.	YES	NO
15	I am lucky in everything I do.	YES	NO
16	I allow to be directed to often.	YES	NO
17	Usually, when I have to change something in my life, I feel tension and lack of confidence.	YES	NO
18	It is stupid to contribute to others people's successes.	YES	NO
19	Bad weather completely upsets me.	YES	NO
20	I know well what is good and what is evil.	YES	NO
21	I am good for nothing, I will never achieve anything in life.	YES	NO
22	I like sexual arousal.	YES	NO
23	It is not possible to share feelings with someone who has not experienced what I have.	YES	NO
24	My docility impedes my life.	YES	NO
25	I often have a feeling of inner emptiness.	YES	NO
26	I know that I will not fend for myself in the future.	YES	NO
27	Nobody really cares about me.	YES	NO

28	I like making decisions quickly.	YES	NO
29	I often feel mentally weak.	YES	NO
30	I have a good rapport with people.	YES	NO
31	I like to have fun.	YES	NO
32	Working is more difficult for me that for other people.	YES	NO
33	My interests change frequently.	YES	NO
34	In the morning I usually vigorously jump out of bed.	YES	NO
35	I cry while watching sad movies more often than others.	YES	NO
36	I am driven first of all by my instinct, intuition.	YES	NO
37	I am very sensitive.	YES	NO
38	Even when things go wrong for me, I do not lose hope that there still is some way out.	YES	NO
39	I feel that nobody needs me.	YES	NO
40	There are some superior forces that decide for me.	YES	NO
41	I have a lot of strength in me, I do not have to force myself to activity.	YES	NO
42	People say that I am as stubborn as a mule.	YES	NO
43	Other people's happiness annoys me.	YES	NO
44	I almost always feel lonely.	YES	NO
45	It sometimes scares me how much I can get furious with myself.	YES	NO
46	I often explore myself to exhaustion.	YES	NO
47	I happen to beat a family member or a friend.	YES	NO
48	I like doing something dangerous.	YES	NO
49	I find it difficult to differentiate which matter is more important and which is less important.	YES	NO
50	I feel more self-confident than most people.	YES	NO
51	I like to be alone.	YES	NO
52	After I quarrel with somebody, I am very angry with myself.	YES	NO
53	I am certain that supernatural forces exist.	YES	NO
54	I like to be in the spotlight.	YES	NO
55	I am frequently insulted.	YES	NO
56	Games and betting for money excite me.	YES	NO
57	Only my own needs are important.	YES	NO
58	I often wonder if I can trust my acquaintances.	YES	NO
59	I often think about the people I have harmed.	YES	NO
60	Sometimes I have the feeling that something terrible will happen.	YES	NO
61	I quarrel frequently.	YES	NO
62	I usually quickly forgive those who have treated me badly.	YES	NO
63	The effects of my actions do not depend on me.	YES	NO
64	I feel connected with all the people around me.	YES	NO
65	Usually, before I make a decision, I meticulously analyze all the facts and details.	YES	NO
66	I would like to possess a special power, such as nobody else has.	YES	NO
67	When someone is angry with me, I wait until their anger passes.	YES	NO
68	I usually do what I consider to be right.	YES	NO

69	I get easily worried about trifle things.	YES	NO
70	I know what I am heading for in life.	YES	NO
71	When I am in a difficult situation, there is always someone to help me.	YES	NO
72	It happens frequently that strangers stare at me critically.	YES	NO
73	There are spirits that help or harm.	YES	NO
74	I think for a very long time before I choose something.	YES	NO
75	When someone is saying drivels, I usually tell him/her about it.	YES	NO
76	Most of the people close to me completely do not understand me.	YES	NO
77	Difficult situation is a challenge or a chance.	YES	NO
78	I know that I am often unbearable.	YES	NO
79	Religion helps me in life.	YES	NO
80	I often pay back the people who have hurt me.	YES	NO
81	If I forget to be careful, I often fail.	YES	NO
82	I enjoy someone else's misfortune.	YES	NO
83	I like inventing new modes of action.	YES	NO
84	I do everything very slowly.	YES	NO
85	Being understanding to people does not lead to anything good.	YES	NO
86	When I have problems, I work out a plan of action and I follow it.	YES	NO
87	My relations with people break down and improve alternately.	YES	NO
88	I am often plagued by memories of the wrong things I have done.	YES	NO
89	I like to play tricks.	YES	NO
90	I am afraid to do something new.	YES	NO
91	I have no influence on what I am like.	YES	NO
92	I find it difficult to work when nobody helps me.	YES	NO
93	I am excited and pleased about every change in my life.	YES	NO
94	Before I sign any document, I always read it whole carefully.	YES	NO
95	I have difficulties with giving orders.	YES	NO
96	I believe that miracles do happen.	YES	NO
97	It is easy to hurt me.	YES	NO
98	In situations where there are many options to choose from, I cannot decide on anything.	YES	NO
99	I prefer "going the whole hog" rather than being too cautious.	YES	NO
100	My relations with people are not as good they should be.	YES	NO
101	I often try to do more than I am actually able to.	YES	NO
102	I am less vigorous than most people.	YES	NO
103	When things get difficult, I fantasize that they are entirely different.	YES	NO
104	When someone shows me kindness, I wonder what lies behind it.	YES	NO
105	They sometimes tell me that I have too high opinion of myself.	YES	NO
106	During family celebrations I feel alienated.	YES	NO
107	When I am in a difficult situation, I accept the fate.	YES	NO
108	Strong emotions should be avoided, they tire you out too much.	YES	NO
109	I could devote my life to making the world a better place.	YES	NO

110	Life is a constant effort for me.	YES	NO
111	Typically I have a lot of energy throughout the day.	YES	NO
112	I easily lose control of myself.	YES	NO
113	I often burst out for trivial reasons.	YES	NO
114	I often have no strength to finish what I want to do.	YES	NO
115	It is difficult for me to accept any refusal.	YES	NO
116	I am always relaxed, even when everyone around me is nervous.	YES	NO
117	I want to have greater wealth than others.	YES	NO
118	I easily talk about my personal problems, even to the people I do not know well.	YES	NO
119	Most people are not worth a lot.	YES	NO
120	I change my mind depending on who am I talking to.	YES	NO
121	One should always stick to the rules.	YES	NO
122	I often get angry with myself.	YES	NO
123	I am afraid of insolent people.	YES	NO
124	I often feel discouraged with how my life has worked out.	YES	NO
125	I often say something impulsively, which I regret later on.	YES	NO
126	I give up my plans very often.	YES	NO
127	I want to act in such a way to satisfy anyone.	YES	NO
128	My pleasures are more important than the other person's problems.	YES	NO
129	I often take over the leadership role while working with others.	YES	NO
130	I frequently lie as otherwise I will end up at a loss.	YES	NO
131	Failures discourage me to everything.	YES	NO
132	I have sometimes volunteered for unpleasant tasks.	YES	NO
133	I almost always make decisions based on a first impression.	YES	NO
134	I do have things I can be proud of.	YES	NO
135	I evade rules frequently.	YES	NO
136	Attractive people make me feel very embarrassed and shy.	YES	NO
137	I usually direct myself according to horoscopes and fortune telling.	YES	NO
138	I am a very delicate person.	YES	NO
139	After I quarrel with someone, I do not speak to that person for some time.	YES	NO
140	I can refuse.	YES	NO
141	I often ponder over what am I like.	YES	NO
142	I like flirting.	YES	NO
143	I think that I will be very lucky in the future.	YES	NO
144	I am usually composed.	YES	NO
145	I give much thought to what I do very often.	YES	NO
146	When I get angry I tend to hit someone or throw things.	YES	NO
147	I have experienced the influence of supernatural forces.	YES	NO
148	When I lose support in a close person, I must find someone to take care of me.	YES	NO
149	I am often a victim of a confluence of adverse circumstances.	YES	NO
150	Nobody is interested in what I feel.	YES	NO

151	I have too little faith in me.	YES	NO
152	People often tell me that I show no consideration for others.	YES	NO
153	I am usually satisfied with myself.	YES	NO
154	Nothing works out in my life the way I would like to.	YES	NO
155	I am so overworked that I have no time for entertainment.	YES	NO
156	I know that I am worth less than others.	YES	NO
157	I pay special attention to details in everything I do.	YES	NO
158	When I am in a difficult situation I expect that something will save me.	YES	NO
159	I do not sleep well in a new place.	YES	NO
160	Even when everything goes well, I often give up.	YES	NO
161	It is unfair that others have more than I do.	YES	NO
162	People accuse me of being too independent, because I do not do what they want.	YES	NO
163	I could easily move out to some other place.	YES	NO
164	I am frequently disappointed with people.	YES	NO
165	No matter how great the difficulties are I always hope for the best.	YES	NO
166	My life is meaningless.	YES	NO
167	I like to share all my experiences and feelings with my friends.	YES	NO
168	I often miss life chances because I withdraw needlessly.	YES	NO
169	I am a pedant.	YES	NO
170	Even when I am trying my best, I do not work as fast as others.	YES	NO
171	My mood swings exhaust everyone, even myself.	YES	NO
172	I often dream that I am a millionaire.	YES	NO
173	Making quick decisions is difficult for me.	YES	NO
174	I am ready to sacrifice my own matters only to be liked.	YES	NO
175	I often wonder how others relate to me.	YES	NO
176	I have a tendency to worry without any special reason.	YES	NO
177	Any kind of oddity, strangeness, unnaturalness annoys me.	YES	NO
178	I frequently do things against my will.	YES	NO
179	I usually hope that someone else will solve my problems for me.	YES	NO
180	I demand from myself more than most people do.	YES	NO
181	When I am among people, I often have a feeling of loneliness.	YES	NO
182	I usually feel that everything will be fine.	YES	NO
183	Sometimes I humiliate myself.	YES	NO
184	I often belatedly realize that I have needlessly let myself to be convinced.	YES	NO
185	It is worse for me than for others.	YES	NO
186	Sometimes I do something dangerous just for pleasure.	YES	NO
187	I do not care at all whether people like me or not.	YES	NO
188	I often feel like a powder keg before an explosion.	YES	NO
189	I can be very resolute when the situation demands it.	YES	NO
190	Other people have too much control over me.	YES	NO
191	It is not worth losing time with the people who mean nothing.	YES	NO

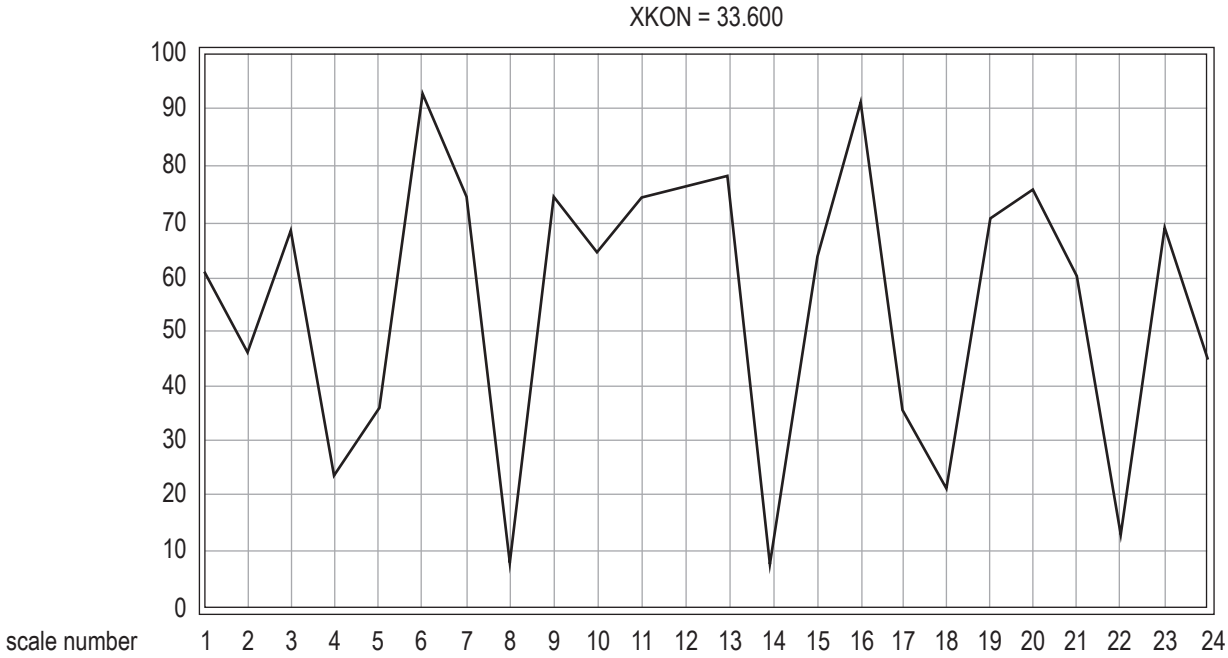
192	I always must be certain that I have not made any mistake.	YES	NO
193	After I quarrel with someone, I try to quickly reconcile.	YES	NO
194	I like when someone directs the things I am supposed to do.	YES	NO
195	It is difficult to convince me, I do not change my mind easily.	YES	NO
196	I often wait for someone else to take the initiative.	YES	NO
197	I can think clearly in difficult situations.	YES	NO
198	My life depends on circumstances which I have no impact on.	YES	NO
199	It irritates me when someone interrupts in what I do.	YES	NO
200	I "get lost" in life.	YES	NO
201	In situations of tension and rush, I feel completely helpless.	YES	NO
202	When I look at myself in the mirror, I feel disgust.	YES	NO
203	I have enough of everything very often.	YES	NO
204	I usually go by what I feel in a given moment.	YES	NO
205	Every time when I say something about myself, I "get it in the neck".	YES	NO
206	I often imagine that I am someone great.	YES	NO
207	I always want to do what I have to as fast as possible.	YES	NO
208	I am very emotional.	YES	NO
209	Failures mobilize me to make effort.	YES	NO
210	One should always be faithful to the principles, even when they disturb one's life.	YES	NO
211	I usually cannot protect myself when someone is hurting me.	YES	NO
212	I like travelling.	YES	NO
213	I usually know what should be done.	YES	NO
214	I prefer to spend my life alone rather than getting involved with someone.	YES	NO
215	I often have no impact on what I do and how I do it.	YES	NO
216	I can deal with my troubles.	YES	NO
217	I easily return to an interrupted work.	YES	NO
218	Most of the people I know take care only of their own business.	YES	NO
219	I deserve to be treated in a special way.	YES	NO
220	I am always meticulously thorough, even when I must hurry.	YES	NO
221	I never doubt in what the people in authority say.	YES	NO
222	I want to be admired more than others are.	YES	NO
223	My fate depends first and foremost on me.	YES	NO
224	Most people are more resourceful than I am.	YES	NO
225	I often dream about an ideal romance, which I will have one day.	YES	NO
226	It infuriates me when someone is making fun of me.	YES	NO
227	Music, poetry touch me deeply.	YES	NO
228	I am often cruel to the people close to me.	YES	NO
229	I sometimes forget about something that in fact I do not want to do.	YES	NO
230	I frequently have pangs of conscience.	YES	NO
231	Sex is one of the most important things in my life.	YES	NO
232	In today's world an honest man must lose.	YES	NO

233	I usually do things my own way, not yielding to anyone.	YES	NO
234	I do not like looking at myself in the mirror.	YES	NO
235	I often behave in a way that annoys the people around me.	YES	NO
236	People look for my help and understanding.	YES	NO
237	I constantly reproach myself for something.	YES	NO
238	Sometimes I dream about fame, recognition, the position I will attain in the future.	YES	NO
239	Almost every difficulty can be overcome.	YES	NO
240	I have to be careful because it is easy to take advantage of me.	YES	NO
241	I easily give in during a quarrel.	YES	NO
242	I get tired more quickly than most people.	YES	NO
243	Every day I am trying to take a step towards the realization of my own goals.	YES	NO

APPENDIX 2

EXAMPLE OF KON-2006 RESULTS

(before treatment, 36 years old women, diagnosed as GAD)



SCALES (temporary names): 1. “Feeling of being dependent on the environment”; 2. “Asthenia”; 3. “Negative self-esteem”; 4. “Impulsiveness”; 5. “Difficulties with decision making”; 6. “Sense of alienation”; 7. ”Demobilization”; 8. “Tendency to take risks”; 9. ”Difficulties in emotional relations”; 10. “Lack of vitality”; 11. “Conviction of own resourcelessness in life”; 12. “Sense of lack of control”; 13. “Deficit in internal locus of control”; 14. “Imagination, indulging in fiction”; 15. “Sense of guilt”; 16. “Difficulties in interpersonal relations”; 17. “Envy”; 18. “Narcissistic attitude”; 19. “Sense of being in danger”; 20. ”Exaltation”; 21. “Irrationality”; 22. “Meticulousness”; 23. „Ponderings”; 24. “Sense of being overloaded”

APPENDIX 3

ITEMS OF SYMPTOM CHECKLIST "O"

These items concern symptoms and difficulties that sometimes occur in neurotic disorders. Please read every item carefully and circle the answer that best indicates the intensity of your symptoms during the last week. Please use this key:

0 = this symptom did not occur during the last week
a = this symptom occurred at a slight intensity during the last week
b = this symptom occurred at a moderate intensity during the last week
c = this symptom occurred at a strong intensity during the last week

1.	Fear whenever you are on a balcony/ bridge/ or the edge of a cliff	0 a b c
2.	Feelings of sadness (gloom)	0 a b c
3.	Choking sensations/ like the feeling of a „lump" in the throat	0 a b c
4.	Persistent feelings of fear without any reason	0 a b c
5.	Frequent crying	0 a b c
6.	Feelings of fatigue and weakness in the morning that disappear during the day	0 a b c
7.	Dissatisfactions with sexual life	0 a b c
8.	Impressions that familiar things have become unknown and strange	0 a b c
9.	Vomiting in stressful situations	0 a b c
10.	Feelings of discomfort in large groups	0 a b c
11.	Skin itching or rashes that disappear quickly	0 a b c
12.	Checking over and over whether everything is done correctly (the door locked, the oven turned off, and so on)	0 a b c
13.	Muscle cramps that always happen during certain activities – for example, fingers cramp during writing or playing music and so on	0 a b c
14.	Dizziness	0 a b c
15.	Lack of self-dependence	0 a b c
16.	Feelings of annoying internal tensions	0 a b c
17.	Discovering all kinds of serious diseases in ,yourself	0 a b c
18.	Compulsive, bothersome thoughts, words/ or fantasies	0 a b c
19.	Nightmares/ frightening dreams	0 a b c
20.	Strong heartbeats (palpitations) without any physical activity	0 a b c
21.	Fear and other unpleasant sensations whenever staying alone, for example in an empty room and so on	0 a b c
22.	Feelings of guilt/ blaming yourself	0 a b c
23.	Loss of sensitivity in parts of the body	0 a b c
24.	Petrifying unexplainable fear that stops you from any kind of intensive experiencing of any unpleasant events	0 a b c
25.	Very intensive experiencing of any unpleasant events	0 a b c

26.	Problems with memory (getting worse)	0 a b c
27.	Difficulties in sexual life because of – for example, tension of muscles in women or early ejaculation in men, and so on	0 a b c
28.	Feeling as if the world is in a fog	0 a b c
29.	Persistent headaches	0 a b c
30.	Strongly bothered by feelings that you have no one really close to you	0 a b c
31.	Wind (flatulence), or involuntary passing of gas	0 a b c
32.	Frequently repeating the same acts that seem strange or unnecessary	0 a b c
33.	Stuttering or stammering	0 a b c
34.	Feeling flushes of blood into the head	0 a b c
35.	Annoying lack of self-confidence	0 a b c
36.	Losses of attention that interrupt your activity	0 a b c
37.	Performing ritualistic actions to try to avoid disease	0 a b c
38.	Persistently fighting with thoughts of hurting or insulting someone	0 a b c
39.	Difficulties in falling asleep	0 a b c
40.	Heart pain	0 a b c
41.	Fear whenever in a car, train, .bus, or so on	0 a b c
42.	Lack of self-confidence	0 a b c
43.	Temporary (periodic) paralyses of legs or hands	0 a b c
44.	Attacks of panic	0 a b c
45.	Experiencing emotions strongly and deeply	0 a b c
46.	Feeling that your thinking is slower and not as clear as usual	0 a b c
47.	Aversions to sexual contacts with persons of the opposite sex	0 a b c
48.	Feeling that the world is unreal	0 a b c
49.	Dryness of the mouth	0 a b c
50.	Avoiding people, even those close to you	0 a b c
51.	Fainting	0 a b c
52.	Strong internal desires to do useless things – for example, washing hands constantly and so on	0 a b c
53.	Sudden involuntary movements (tics)	0 a b c
54.	Loss of appetite	0 a b c
55.	Being helpless in life	0 a b c
56.	Nervousness (restlessness) in performing that decreases your effectiveness	0 a b c
57.	Pertinent concerns over body functions – for example, heart-beats, pulse, digestion, and so on	0 a b c
58.	Obsessive: immoral thoughts	0 a b c
59.	Attacks of hunger – for example, the necessity to eat at night	0 a b c

60.	Feelings of heat or (and) cold without reasons	0 a b c
61.	Fears whenever you are in open places – for example, in large square, field, and so on	0 a b c
62.	Desire to take your life (suicidal thoughts)	0 a b c
63.	Periodic blindness or deafness	0 a b c
64.	Apprehensiveness	0 a b c
65.	Inability to control your emotions despite the consequences	0 a b c
66.	Difficulty in concentration	0 a b c
67.	Decrease or lack of sexual desire	0 a b c
68.	Feelings of strangeness of one's own body	0 a b c
69.	Diarrhea	0 a b c
70.	Shyness and embarrassment with persons of the opposite sex	0 a b c
71.	Fears or other unpleasant sensations that appear only in locked (closed) spaces	0 a b c
72.	Apathy – showing down of activity and thinking	0 a b c
73.	Aphonia – inability to speak that suddenly appears and suddenly disappears	0 a b c
74.	Constipation	0 a b c
75.	Feelings of being worse than other people	0 a b c
76.	Destroying things when you are angry or upset	0 a b c
77.	Fears about one's own health and about contracting serious diseases	0 a b c
78.	Persistent obsessive counting – for example, pedestrians, cars, lights, and so on	0 a b c
79.	Frequently waking up during sleep	0 a b c
80.	Reddening (blushing) on the face, neck, or chest	0 a b c
81.	Fears when in crowds	0 a b c
82.	Pessimism, expecting failure or disaster in the future	0 a b c
83.	Faintness in difficult or unpleasant situations	0 a b c
84.	Feelings of being threatened – without any reason	0 a b c
85.	Unexpected strong feelings of happiness, joy, ecstasy	0 a b c
86.	Constant fatigue	0 a b c
87.	Unpleasant feelings connected with masturbation	0 a b c
88.	Feelings that you are living as if in a dream	0 a b c
89.	Trembling of legs, hands, or whole body	0 a b c
90.	Feeling that people influence you easily	0 a b c
91.	Allergic symptoms – colds, hay fevers, swellings and so on	0 a b c
92.	Internal pressure to perform acts very slowly and exactly	0 a b c
93.	Muscle cramps in different parts of the body	0 a b c
94.	Excessive saliva in the mouth	0 a b c

95.	Losing yourself in daydreams..	0 a b c
96.	Attacks of anger, hostility, that you cannot control	0 a b c
97.	Feelings of haying serious diseases that threaten your life	0 a b c
98.	Excessive thirst	0 a b c
99.	Insomnia	0 a b c
100.	Feelings of chill or heat without reason	0 a b c
101.	Fears of contact with things, animals, or places that are not dangerous	0 a b c
102.	Lack of energy and strength in any kind of activity	0 a b c
103.	Difficulties in breathing – for example, breathlessness that appears and disappears suddenly	0 a b c
104.	Feelings of apprehension (dread) before meetings, and so on	0 a b c
105.	Feeling that people do not thing highly of you	0 a b c
106.	A lowering in the speed of thinking and perceiving	0 a b c
107.	Pains or other disorders in the sexual organs	0 a b c
108.	Impressions that you have seen something before when you really have seen it for the first time	0 a b c
109.	Unpleasant feelings or pains under the influence of noise, bright light, delicate touch	0 a b c
110.	Feelings that people do not like you (are prejudiced against you)	0 a b c
111.	Involuntary passing of urine, for example during sleep	0 a b c
112.	Excessive drinking of alcohol	0 a b c
113.	Trembling of ,the face, eyelids, head, or other parts of the body	0 a b c
114.	Excessive perspiration in stress situation	0 a b c
115.	Feelings of being under the influence of the environment	0 a b c
116.	Persistent feelings of anger and hostility	0 a b c
117.	Undefined „traveling” pains	0 a b c
118.	Feelings of rebelliousness	0 a b c
119.	Sleepiness during the day that forces you to fall asleep for a while, despite the situation	0 a b c
120.	Flushing (a rush of blood) to your head	0 a b c
121.	Fears about the safety of close relatives that are not in any danger	0 a b c
122.	Feelings of inferiority when compared to other people	0 a b c
123.	Disorders of balance	0 a b c
124.	Fears of doing something terrible or of something terrible happening	0 a b c
125.	Feelings that people do not care about you and your problems	0 a b c
126.	Pressure (floods) of thoughts.	0 a b c
127.	Menstrual disorders in women	0 a b c
128.	Feeling low intensities of emotions	0 a b c
129.	Feelings of muscle tensions	0 a b c

130.	Need to be alone	0 a b c
131.	Heartburn	0 a b c
132.	Passing urine frequently	0 a b c
133.	Cramps (spasms) that force you to turn your head	0 a b c
134.	Muscle pains – for example, in. The back, chest, and so on	0 a b c
135.	Buzzing in the ears	0 a b c
136.	Nausea	0 a b c
137.	Decrease in sex drive	0 a b c
138.	A feeling that you have already been in a place or a situation while in fact it is the first time	0 a b c