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Diagnostic characteristics of the language of the neurotic patient's presenting first complaint: A case analysis

Dorota Stolarska

This paper explains the diagnostic procedure that is used when dealing with patients with functional disturbances who have come for psychotherapy, and presents an analysis of the patient's presenting complaint. The procedure's possibilities, limitations, and ways of interpretation are discussed as they apply to a case of one neurotic patient at the Cracow Regional Therapeutic Centre.

Key words: diagnostic procedure, language analysis

The process of diagnosing in clinical psychology is defined as an activity aimed at explaining a person's specific functioning from the point of view of the genesis of this functioning, its psychological mechanisms and its effects. Understanding the complex sphere of phenomena that leads to the formation of pathological mechanisms of experience, the patient's behaviour, and somatic processes (in the case of neurotic disorders) must obviously assume a specific structure. This structure includes data obtained through clinical methods (observation, interviews, the patient's history and an analysis of productions) as well as test methods. More rarely, it also includes experimental data.

Once the information has been collected, a general hypothesis can be formulated, which must later be theoretically verified and therapeutic goals must be determined. Of course the diagnosis, the augmentation of the diagnosis, and its continuous verification take place during the patient's psychotherapy [7, 27, 29].

A diagnostic procedure that uses an analysis of the presenting complaint language of the neurotic patient undergoing psychotherapy was introduced and described by J.W. Aleksandrowicz [1,2,3]. This procedure has been applied to patients at the Regional Centre for Treatment of Neurotic Disorders in Cracow for several years. The procedure is based on the structural theory of psychogenic functional disorders, which belongs to current psychodynamic conceptions. Aleksandrowicz claims that "the occurrence

in a given individual of functional disorders – both in the sphere of body organs and in the area of experiencing and behaviour – forms a specific style of an individual's functioning in his/her contacts with other persons, i.e., in the contacts aimed at achieving satisfaction of psychosocial needs" [1, p. 59]. The area in which psychosocial needs are satisfied by the individual is the so-called psychosocial field, a term introduced by K. Lewin [Lewin K.1975]. This field is determined, on the one hand, by the given person and his/her set of needs, and, on the other hand, by other people who are able to satisfy them (whether in reality or in the subject's imagination).

Thus, the psychosocial field is composed of a set of interacting dynamic forces, their development, and how they change over time. According to Aleksandrowicz, the individual's actions, which are aimed at satisfying his/her psychosocial needs, can be considered as a form of language. Therefore, the various forms of functioning in the psychosocial field can be analysed in terms of structural linguistics. The individual styles of communication and specific "paroles' of particular individuals can be grouped as belonging to one class – "langue" [20]. Functional disturbances, i.e., symptoms, are also treated as signs of an element of language. The language of symptoms not only expresses something – it also constitutes a set of signals or stimuli that are expected to affect the people to whom they are addressed. Understanding symptoms as a language allows us to recognise that through his/her symptoms, the individual transmits not only what is happening within himself/herself, but also what is taking place between himself/herself and other people. This allows us to recognise that the language of functional disturbances, like any other language, plays both an expressive role and the communicative one.

The procedure described above takes place during the patient's first meeting with the physician to whom the patient is directed by a psychiatrist after the latter has formulated a diagnosis of functional disturbances. The procedure consists of asking a possibly neutral question, e.g., "What is the reason for your visit here?" or "Yes, how can I help you?" and refraining from asking any other questions – even if the patient is silent for a long while. In response to this kind of question, the patient usually "delivers" a longer or shorter monologue. The monologue is recognised as complete when the patient breaks his/her speech for a longer period, and marks its end either verbally, with expressions such as "and that's all" – or non-verbally, by waiting for the start of a dialogue in silence. During the patient's speech, the physician's attitude is as neutral as possible. The speech is recorded, then transcribed and analysed. Obviously, the patient is informed that his/her speech is recorded; patients seldom refuse to give consent to have their speech recorded, nor do they demand a further explanation. This issue of consent was discussed in detail, i.a., by H. Thoma and H. Kachele [33], who claimed that "the specific influence of this variable can be isolated and elaborated in a therapeutically constructive way. Some problems manifest themselves even faster, which indicates that the projection of semantic content to a tape can be a starting point for a constructive dialogue" [33, p. 330].

When the opening question is formulated in the manner described above, i.e., when it is not selectively directed to one area of information such as a description of ailments (we do not ask questions like "What is your complaint?"), it evokes in

the patient a sequence of associations regarding his/her disturbances. This procedure allows for an analysis of the material obtained from the patient – not only by asking precisely directed diagnostic questions (as it is done in a structured interview or a psychopathological examination) – but also through stimulating a relatively free association sequence. Therefore, the content of the patient's narrative, and the form in which the narrative is delivered, are extremely important. This association sequence and its format comprise both conscious and unconscious information concerning the patient's disorders, his/her expectations connected to future therapy, and provide a way of establishing contact with the physician. In addition to other factors, this association sequence may reveal significant relations between functional disturbances, i.e., symbols, and those situations and circumstances that are taking place in the patient's life, which are symbolised by the symptoms.

This procedure is aimed at minimising the factors that disturb the diagnostic process. This is achieved by the interactive method of examination: stimulation with a general question, the physician's neutral attitude, and fact that the narrative is recorded. One should remember, however, that it is a microscopic examination of a fragment of information. Moreover, it is obvious that the examining person, who is taking part in the interaction, exerts his/her influence on the character of the phenomena that occur in this field. The psychopathological picture of an individual syndrome is not exclusively dependent on the properties of the person being examined. It achieves its specific quality firstly because of the specific features of the relationship – and not because of the specific features of the patient. The picture of the disturbances assumes a specific form in a way that is concurrent with the ideas concerning the patient's role. The examining person, or rather his/her social role, influences this concretetization in a positive way. The examiner, his/her style of conducting the examination, theoretical orientation, personality traits, etc., cause certain disturbances to arise from the very situation of examination. The selective characteristics of the examiner's perception may also influence the result of the diagnosis, and his/her emotional attitudes during the meeting with the patient are not devoid of meaning either. If the above factors are not taken into consideration, they may significantly distort the result of the diagnosis.

Aside from the remarks and indications of the author of the monologue analysis [1, 2, 3], its possible forms have yet to be studied. When attempting to construct such forms that would be clinically useful, we should briefly consider the available studies on language in psychiatry and psychotherapy. Interest in language in psychiatry began with Freud [13, 14]. Psychoanalysis began to focus its attention on the language of the patient's narratives, treating the language as an instrument for aiding our understanding of the disorder. Psychiatrists began to notice manifestations of the influence of unconscious factors in the language of neurotic patients—in the symbols, metaphors, slips of the tongue, deformations, transpositions, contaminations, substitutions, etc. At this point we should mention J. Lacan's theory [20] of developing psychoanalysis based on anthropology and structural linguistics. Lacan's theory strongly emphasises the role of language – both of that which is common for some language areas, cultural, and that which is individual ("langue", "parole"). One of the most important elements in Lacan's conception, which is still subject to dispute, is the statement that the structure

of unconsciousness is identical with that of a language.

The contemporary current in studies on the language of psychotherapy consists mostly of an analysis of formal and semantic features of verbal behaviours, and looks for relations between verbal behaviours and personality features. Psychotherapists also pay significant attention to the study of the psychotherapeutic process based on language analysis.

In an analysis of formal features of the language, we should consider, i.a. the works of Jeanneau [16], Fraser et al. [12], Morice R.D. and Ingram J.C.L [26], Lorenz M. and Cbb S. [23], von Rad et al. [31]. These works indicate that neurotic persons use delicate words, first person pronouns, conjunctions, comparisons, negations and the so-called adoptive expressions (such as and so, maybe, as regards, I suppose, I mean, I think that), more often than other patients (psychotic or borderline patients). More than with any other diagnostic groups, neurotic patients use nouns, adjectives, and verbs that have an emotional load, both positive or negative, for example terrible, I hate, I adore, horrifying, shocking, etc. Their sentences also tend to be more complex and longer. Studies conducted by Jeanneau [35] confirmed that these traits in the language of neurotic persons manifest their ability to test their reality and integrated personality, and indicate a high level of defensive mechanisms.

According to this investigator, the patients' ability to test reality is indicated by frequently occurring "shifters" at the language level – words that connect the elements of narrative with the situation in which this narrative takes place, referring to the common world of the speaker and the recipient. This function, called deictic, i.e., indicative, is usually performed by demonstrative pronouns, personal pronouns, time adverbs, and place adverbs. For example, in the system of defensive mechanisms, expulsion and negation have specific linguistic references. Jeanneau refers to the opinion expressed by Lacan, and states that expulsion is strictly connected with the language and the patient's ability to symbolise. We could say that the will to speak about oneself in a natural and integrated way is a sign of functioning of the expulsion mechanism. Similarly, expressing negation is characteristic of neurotic people who use an expression with the negative value. For instance, they can negate a desire that has hitherto been expelled.

Studies conducted by Weintraub and Aronson [35] on defence mechanisms manifested in verbal behaviours are also very relevant. According to the authors, indicators of these mechanisms include: the number of words, the duration and number of breaks, speed of expression, non-personal references, references to the past, negations, impairments, explanations, expressions of feelings, evaluations, direct references to the therapist, etc.

There are several works on the topic of linguistic analysis during treatment that should be recognised as very important. These include studies by L.A. Gottschalk [15], who developed the method of Content Analysis. Works by D.A. Shapiro and R.R. Elliot [1992] are devoted to the structure of verbal exchange in the short-term psychotherapy of the psychodynamic-interpersonal and cognitive-behavioural type. Moreover, there are L. Luborsky's studies [24] on the importance of the context of a patient's narrative for understanding the meaning of a symptom; studies on the discourse in psychotherapy

conducted by i.a., A. Madill, K. Doherty [25]; and an examination of the process of treatment on the basis of language analyses by i.a., Kachele and Thoma [33].

Discussion on methodology

I found few works on this subject in Polish literature. Most works seem to deal with language disturbances in schizophrenia [9, 36], and include syntactic, lexical and discoursive analyses, or with functions of meta-text elements.

The experience acquired by the team of the Regional Centre for Treatment of Neuroses in Cracow in the field of monologue analysis encouraged me to study the forms of such analyses, and to test the diagnostic usefulness of the procedure applied by our team. This paper does not present a complete discussion of my research; instead, I will discuss and illustrate the procedure using the example of the presenting complaint analysis of one of our patients. In the analysis, I will use the categories of characteristic features of the presenting complaint of neurotic patients, which I worked out on the basis of existing literature and my own experience [unpublished study].

In the first group, that of content categories (CC), I distinguished the following subcategories:

1. The patient's statements concerning somatic disorders (i.e., problems in the gastrointestinal system, circulatory system, respiratory system, motor organs, senses, etc.).
2. The patient's statements concerning disturbances in experiencing (i.e., fear, sadness, anxiety, irritation, anger, memory disturbances, asthenia, etc.).
3. The patient's statements concerning behavioural disturbances (i.e., shyness, dependence, impetuousness, perfectionism, etc.).
4. Statements concerning the circumstances under which the symptoms occurred:
   – a description of a situation that triggered the symptoms,
   – a list of typical circumstances under which the symptom occurs,
   – indicating the individual circumstances of symptom occurrence,
   – emphasising the lack of specific, characteristic circumstances of symptom oc–currence, the inability to conceive the circumstances, incidental circumstances, and insignificant stimuli that trigger the symptoms,
   – others.
5. The patient's statements concerning the time when symptoms occur (described precisely or in general terms):
   – since when the symptoms have occurred,
   – how long they persist,
   – at what intervals.
6. Statements concerning the intensity of ailments.
7. Statements concerning the hitherto treatment and type of contact with physicians:
   – case history,
   – expression of iatrogeny, dissatisfaction with the hitherto treatment,
   – reference to the authority of the physicians the patient has contacted,
   – signals of seeking closeness, sense of belonging, etc., in regard to contacts with physicians, e.g., the expression "my doctor",

– others.

8. Statements concerning the patient's own understanding of his/her illness:
   – the patient names the causes of the disorder,
   – the patient names the difficulties in describing and recognising the causes,
   – the patient negates the causes of the disorder.
9. Statements concerning expectations connected with the therapist:
   – the patient's formulating his/her expectations,
   – the patient's quoting expectations of other persons, e.g., the family, regarding his/her therapy.
10. Statements about functioning within the patient's family:
    – a sense of satisfaction or dissatisfaction with the most important needs (emotional, sexual, safety, etc.),
    – a sense of fulfilment or non-fulfilment of tasks (e.g., marital tasks, parental tasks, taking care of another person, or tasks that issue from the role of a child).
11. Statements about functioning in occupational roles:
    – satisfaction (or dissatisfaction) with achievements at school or at work,
    – a sense of satisfaction or dissatisfaction with the kind of work,
    – a sense of freedom of choice in the executed tasks or lack of freedom,
    – a sense of occupational stability or instability.
12. Statements about functioning in social roles:
    – having friends and acquaintances or not having them,
    – having a satisfying or dissatisfying way of spending free time.
13. Statements concerning the patient's perception of himself/herself, the patient's convictions concerning his/her own person, his/her emotional attitude towards himself/herself.
14. Statements concerning the physician performing the examination, or direct questions, critique or request addressed to the physician.

In the second group, that of formal categories (FC), I needed to select only some aspects of language analysis. In choosing these aspects, I was guided, on the one hand, by contemporary tendencies in psycholinguistic studies [17, 18, 19] conducted in psychotherapy and psychiatry. On the other hand, I was determined to make the indicators relatively simple so that they could be commonly applied by psychologists and psychiatrists without requiring specialist knowledge. Accordingly, I distinguished the following categories:

1. The course of subject threads: In what sequence they appeared, which of the treads was broken, which were left unfinished, and what thread was used as a substitution,
2. The context in which statements concerning somatic disorders, disturbances in experiencing, and behaviour occurred,
3. Metaphors that occurred in the patient's narrative [21],
4. Slips of the tongue,
5. The number of words in the patient's presenting complaint,
6. The number of intervals, or breaks, in the patient's narrative:

– short (3-5dots) – ca. 5 sec.,
– medium (5-10 dots) – ca. 5–20 sec.,
– long (more than 10 dots) – longer than 20 sec.,
– filled [28],
– in what topic or between which topics the breaks occurred,

7. Dogmatism index[1] [17, 11],
8. Functions of meta-text elements[2] [28],
9. Syntactic analysis of the number of:
   – single clauses,
   – two-clause coordinate sentences,
   – multi-clause coordinate sentences,
   – two-clause subordinate sentences,
   – multi-clause subordinate sentences [34]

These categories had been tested by competent referees and had achieved a high level of concordance rate [unpublished study].

As previously stated, I wish to discuss the diagnostic features of neurotic patients’ language, by basing it on a presenting complaint analysis of one of our patients. The patient, a 30-year-old male, came for psychotherapy because of functional disorders. He was admitted by a middle-age, male physician. The patient’s first narrative was as follows:

“I was directed by my plant physician to the neurotic disorders outpatient clinic, because he recognised a suspicion that my symptoms, which ... with which I came to the plant physician have a nervous background simply, and this caused that I was sent, I came ... I would simply like to start treatment. Well, according to the examinations ... conducted at first move, before I came to the physician, the results were uninteresting, the doctor said so, but after ... two weeks, after repeated tests had been made, everything as if came back to normal ... and this was probably why he sent me for treatment ... This seems all I have to say as regards ... that I came here and ... maybe the therapy conducted by this clinic will cause that ... if this neurosis really is in me, it will decrease or it will be cured.”

What is interesting is that the patient gave no information either about the type

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[1] Dogmatism index, distinguished by S. Ertel [11] refers to attempts at finding some structural characteristics of language expressions, which would reflect the cognitive property called by Rokeach dogmatism. This index can reveal cognitive dispositions, such as a tendency to withdrawal, inclusion, finiteness and ordering. It is expressed by the proportion of words: always, never, everything, everybody, nobody, completely, absolutely, undoubtedly, must, have to, must not, necessarily, etc., compared to the proportion of words: sometimes, rarely, many, few, almost, nearly, maybe, doubtfully, also, certainly, etc. The words of types A and B were divided into six categories: stability – variability, no exceptions – exceptions exist, extremity – moderateness, certainty – uncertainty, including – excluding, necessity – possibility.

[2] Meta-text elements or expressions are expressions that refer to communication itself and “either [organise] the process of transmission of the language message or, referring to a part of the spoken text – can speak of it as of a specific being”, e.g., signalise a correction, emphasise the importance of some fragments, etc. [28].

of somatic disorders he experienced, or about disturbances in experiencing and behaviour (CC – 1, 2, 3). He also said nothing about the circumstances in which they occurred (CC – 4), although he started to speak about symptoms – "my symptoms, which ... with which I came" – and then dropped this thread. Perhaps this indicates a conflict – between his wish to signalise the symptoms (if the sentences were finished "occurred and assumed the form, character", etc.) and the circumstances in which they occurred (if the sentences were finished "occurred on – this or that – day ", etc.), or to emphasise his own person ("occurred in myself") – and the desire to submit to the expectations of the physician who claimed that the symptoms were of a neurotic character (the patient quoted this opinion). The patient might have had an impression that it was not the symptoms, but their cause, which was important. In addition, notice the patient's use of the participle "uninteresting". It signifies, on the one hand, that the results were poor. On the other hand, it may be a signal that the patient felt that he was not interesting for the physician.

The patient gave no information regarding the time of occurrence and the intensity of his symptoms (CC – 5, 6). He only mentioned that "the results were uninteresting [...] but ... after two weeks [...] everything as if came back to normal". We can understand this statement either as emphasising the apparent character of the improvement, or as an inconsistency of the patient's general feeling with the test results. The patient used the phrase "as if" and then "probably", expressing doubts and uncertainties that he had not expressed directly to the first contact physician.

The patient mostly gave information about his hitherto treatment and the type of contacts that he had with physicians (CC – 7). Nearly all his narrative refers to the history of treatment. The patient also refers to the authority of the physician whom he contacted before – he does not formulate his own opinions directly. We also find signals in the narrative that the patient is seeking closeness and a sense of belonging, in his contact with a physician: "I was sent by my plant physician". Notice how the patient emphasised twice that it was a plant physician. This raises the question of whether the emphasis is on the patient's connection with the physician or with the plant.

The patient expressed his expectations twice (CC – 9): "I would simply like to start treatment" and " maybe the therapy conducted by this clinic will cause that ... if this neurosis really is in me, it will decrease or it will be cured". In the first sentence, the patient signalises his motivation for treatment. In the second, he doubts the presence of neurosis in himself and excludes his activity from the future process of treatment. This leads us to suspect that the patient's expectations connected with the therapy are ambivalent.

In the patient's monologue, there were no statements regarding the doctor who performed the examination. Neither did it include information about the patient's own understanding of the disorder, his functioning within his family, or his social and occupational roles. He did not say directly how he perceived himself – he described himself indirectly by quoting the physician's opinion. (CC – 8, 10, 11, 12, 13, 14). It is hard to interpret this lack of information, especially because we have no reference to a larger number of patients.

Analysing the monologue from the point of view of its formal features, we notice

that the course of the subject threads was as follows: CC 7-1 or 2, or 3-7-9-7-9. The patient broke threads regarding the symptoms (CC 1, 2, 3) and expectations connected with therapy (CC 9). The meaning of such a course (FC 1) and of not developing the symptom thread (FC 2) has already been mentioned.

In his monologue, the patient used two metaphors (FC 3): "symptoms [...] on the nervous background" and "according to the examinations ... conducted at first move". Thus, the metaphors are standard, or "dead" [21]. The speech lacks distinctive, original metaphors. If we decide to interpret this fact based on this short language sample, we could say that the patient was rather conventional. His narrative did not include any slip-of-the-tongue (FC 4), and consisted of 126 words. As the results of my study of 60 patients with neurasthenic and somatising disturbances show, it is a medium result [unpublished study]. According to the studies conducted by Jeanneau [16], and Weintraub and Aaronson [35], it may signify a prevalence of the expulsion mechanism, but again, this result and its interpretation should be checked in a larger group of patients. The patient's narrative includes seven short breaks and two medium ones. There were no "filled breaks" (FC 6). Two medium breaks are separated by a meta-text unit that completes the reply (FC 8): "This seems all I have to say as regards ... that I came here", and a communicative operator of fragmentation of the narrative (FC 8): "This seems all I have to say as regards ... that I came here", a result of the patient trying to finish his speech and, additionally, emphasise an element that is important for him. An accumulation of breaks and meta-text elements at this point in the monologue may be a sign of an intensive internal activity. They occur between the signals about the patient's experiencing doubts and hesitations regarding the diagnosis of neurotic disorders in him – and the justification for sending him for psychotherapy. In my opinion, this supports the hypothesis about his ambivalent attitude towards treatment. The dogmatism index (FC 7) is 0:4, and characterises the patient as an uncertain, hesitant person. In his narrative, the patient used several meta-text expressions (FC 8), including the unit finishing the reply and the communicative operator of fragmentation of the narrative. In addition, we can find signals of speech correction: "symptoms, which ... with which I came" and " I came ... I would simply like to start treatment". I address the function of these speech corrections while analysing the content categories. The patient's narrative consists of three multi-clause subordinate sentences and one single clause. Sentence scheme is realised and the syntactic-sentential connection of words within a sentence, called linear connotation, is preserved. This confirms the results of studies conducted by Thomas [34] concerning high syntactic complexity in neurotic patients and healthy persons.

An analysis of content and formal categories indicates that the first hypotheses that require verification are those concerning the existence of an unconscious conflict in the patient between the needs of dependence and passivity, and those of independence or, maybe rebellion. The former are expressed by referring to the physician's authority, depending on his/her instructions and quoting his/her opinions. The latter are manifested through doubting or indirectly ruffling the physician's opinions. This may suggest a passive-aggressive feature in the patient's personality. The patient also signalises his doubt regarding the psychogenic character of his disturbances and, therefore, his am-

bivalent expectations concerning therapy. Thus, a question arises whether the above mentioned hypotheses have been confirmed in the complete diagnostic examination.

The patient, Mr. A., had acquired a secondary education. He is married and had one son, but has been living separately for a month. Mr. A. came for treatment because of persistent tiredness, stomach pains, diarrhoea, tension, pressure of thoughts, muscle pains, and excessive perspiration. The symptoms began to occur a year ago. The patient perceived a causal nexus between the occurrence of symptoms and the marriage difficulties he was experiencing at that time. He was diagnosed as suffering from neurasthenic neurosis and personality disorders. Before the start of psychotherapy, he was examined using the Bender test, Benton test and Graham-Kendall test. The results were negative and combined with the result of a neurological examination, excluded an injury of the central nervous system.

The patient later completed the Motivation Check List[3] [6], and the results obtained (in the subsequent scales: 5, 1, 5, 1, 4, 2, 1) indicated a strong motivation for treatment. Thus, the hypothesis about ambivalent attitude towards therapy posed after the analysis of the patient's presenting complaint was not confirmed by the results of this test.

The patient was also examined with the use of the Symptom Check List[4] [4], in which he scored 389 points (above the norm). The most burdensome symptoms the patient marked were tiredness, stomach pains, diarrhoea, tension, pressure of thoughts, muscle pains and excessive perspiration. Noting the relatively high intensity of these symptoms, we find it interesting that the patient did not describe them in his presenting complaint, but preferred to present a more superficial "layer", i.e., the plant physician's opinion about the "nervous background" of his ailments.

Another diagnostic instrument applied in the examination was the Cattell Personality Inventory [5, 8]. The results, calculated on subsequent scales, were as follows: 1, 3, 4, 2, 1, 8, 6, 4, 6, 9, 1, 6, 6, 8. Based on these results, we can conclude that the patient is passive, rigid, reserved, submissive, lacks self-confidence, apprehensive, has

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[3] Motivation Check List, constructed by Aleksandrowicz and Zgud [6], examines the reasons for undertaking therapy and expectations connected with it. It includes seven scales:
– striving to achieve a disappearance of ailments,
– tendency to avoid treatment due to fear of therapy and foreseeing negative social consequences,
– striving to understand the causes of the occurrence of disturbances,
– starting the therapy under pressure of the environment,
– striving to get to know and change oneself,
– expecting to gain secondary profits from the therapy,
– tendency to deny the fact that one suffers from neurosis.
Each scale comprises five statements; for each confirmation of the statement, the patient scores 1 point, and the maximum result on each scale is 5 points.

[4] Symptom Check List – constructed by Aleksandrowicz et al. in 1975 [4] – includes questions directed at revealing somatic disturbances, disturbances of experiencing and behaviour, as well as personality troubles. It comprises 138 questions that refer to 14 qualitative scales (fear, depression, anxiety and tension, sleep disturbances, hysterics, neurasthenia, sexual disturbances, de-realisation, obsessions, difficulties in social contacts, hypochondriac disorders, psychasthenia, and somatic disorders). For each question the patient indicates the intensity of the symptom from a (4 points), b (5 points) to d (7 points). The maximum score is 966; the norm for women is 68 points and for men 48 points.

little resistance to threats and avoiding. These results are in accord with the hypothesis posed, which was based on the patient's presenting complaint analysis.

In Sacks' Unfinished Sentences Test [32], we could recognise a strong idealisation of the patient's parents, especially of his father, a sense of loneliness and hurt, and anger towards the present family. The patient does not accept women in the role of his superiors. In the face of difficulties, he feels unsure, withdraws into himself, and perceives himself as submissive to others.

In the clinical interview, we collected the following information. The patient is the elder of two siblings – his sister is nine years younger. His mother, who had a secondary education, did not work after he was born. When he was three years old, his mother underwent gastric surgery. The patient does not know the details, but he remembers that since then she was always ill. He remembers his "peregrinations" with his mother, as she was being treated by various specialists. Since her illness, his mother became nervy, impulsive, and inconsistent. She beat her son for any reason, so that their neighbours frequently intervened hearing the boy's cries.

The patient was anxious because he could not predict his mother's behaviours. He started school at the proper age and was an average pupil. His mother helped him with his lessons. The father, described as a quiet man, worked as a clerk and often worked overtime, so he seldom was at home. Soon after the patient's sister was born, his mother died of intestinal cancer. The patient remembers that he experienced relief at her death – not sorrow or despair. He only thought that he would stop being afraid at last. For a time, an aunt took care of his sister, while the patient lived with his father, and began to have many duties. Since the mother's death, his father has not had any relationship with another woman. He always told his children that he devoted himself to them. According to the patient, the father favoured his sister. At home, the father preserved the atmosphere of mourning for a long time. He did not allow the children to go to parties or excursions. The patient had few friends. When he finished primary school, he attended car-mechanic secondary school. He graduated, but never worked as a car-mechanic since it turned out that he was allergic to greases. At that time, he was in love with a girl who reciprocated his feelings. However, her parents made her break this relationship because of his low financial status. Mr. A. acquiesced to their decision – he did not fight to preserve the relationship. He felt very injured. Then he started to attend a college where he met his future wife. She initiated the friendship; she was very nice then. After four years, they were married. The patient had his own flat, but his wife did not want to move away from her parents (particularly from her mother). Therefore, they moved in with his parents-in-law, and the patient gave his flat to his sister. From the very beginning, Mr. A. was uncomfortable and lonely in their home. He has a three-year-old son, whom he loves very much. When his former manager (a male) was substituted by a female, Mr. A. began to have problems and conflicts at work, and was soon fired. He applied to the labour court, but lost his case. At first, his wife supported him, but with the prolongation of the period of his unemployment, she pressured him to take any job. On the one hand, the patient looked for a job, although not very intensively, but on the other hand he felt increasingly hurt that his wife and his mother-in-law demanded money from him. His perception of the

situation was that only money and not he counted for these women. He did not quarrel about it with them. He withdrew into himself, feeling helpless and injured. In this period, he started to experience nervous disturbances. He was no longer able to live with his wife. He moved away to live with his father who supported him. His father believes that the patient's wife is a mercenary, and says the patient should divorce her. The patient is afraid to go to his wife's flat, so he does not visit his son. Recently he has found a job in his profession, but the job is poorly paid.

Concluding the diagnostic examinations, we can state that the external, precipitating factor of Mr. A.'s de-compensation and appearance of symptoms was the increasing conflict with the important women in his life – his wife, mother-in-law, and his manager. He felt both forlorn and exploited by them. Those feelings of being exploited were not so much based on reality as on a result of transference of his relationship with his mother. In his experiences, he was supported only by his father, who, however, only strengthened his strategy of withdrawal and avoidance of confrontation. With his symptoms, the patient informed his surroundings about his hurt, his inability to satisfy his expectations, his refusal connected with justification, anger and a desire to punish women. His ailments express his intrapsychic conflicts, i.e., his inability to experience ambivalent feelings towards objects and himself, which arose in the pre-Oedipal period in the relation with his mother. The similarity between his symptoms and the symptoms of his mother's illness may be a manifestation of punishing himself for the anger experienced towards her and, perhaps, for the childhood wish for her death. This illustrates how difficult it is for him to experience the "good" and "evil" aspects of himself [30]. This main conflict is determined by the defensive formation of character traits such as passive aggression, dependence and rigidity.

It seems that the diagnosis of the disorder, based on a complete examination, corresponds with the hypotheses based on the patient's presenting complaint. It is important to emphasise, however, that the procedure of the neurotic patients' presenting complaint analysis is merely an auxiliary procedure. Based on this procedure, we can only formulate diagnostic hypotheses, and even these are sometimes very difficult to formulate.

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Address for correspondence:
Katedra Psychoterapii CM UJ
Lenartowicza 14
31-138 Krakow