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Kwestionariusz objawowy S-III
Symptom Checklist S-III

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Summary

Aim: Symptom checklists enable clinicians and researchers to quickly estimate probability of presence of the neurotic disorder. To achieve this goal, they should include possibly limited number of items, describing the most prevalent symptoms in the disordered population. Fluctuations in that prevalence force researchers to prepare new variants of checklists every few years, therefore the next (current) version of the checklist “S” for screening has been prepared.

Method: The symptom checklist S-III includes items regarding occurrence and intensity of 82 symptoms, chosen according to their highest prevalence in 1872 patients diagnosed before admission to psychotherapy in the years 2004-2008, because of neurotic disorders. There is „truthfulness scale” included in the checklist, that enables estimation of reliability of answers. Norms are calculated in the groups of 301 non-patients and 508 patients before admission to psychotherapy in 2009-2010.
Results: The cutoff point between Global Symptom Levels (GSL) in the nonclinical population and patients before admission to psychotherapy is estimated, and the value of 146 points for both men and women is suggested.

Conclusions: Symptom checklist S-III has satisfactory psychometric properties and can be applied in a quick diagnosis of neurotic disorders occurrence.

Słowa klucze: kwestionariusz objawowy, zaburzenia nerwicowe, badania przesiewowe, diagnostyka
Key words: symptom checklist, neurotic disorders, screening, diagnostics

Symptom checklists, which enable obtaining information about the presence and intensity of functional disorders, have been widely used in both diagnostics and epidemiological studies for many years. The best known is SCL-90, which registers a wide spectrum of symptoms – mostly neurotic, but also psychotic ones [1]. The need for a tool that would be specifically geared to depict neurotic disorders has contributed to the decision of constructing the symptom checklist “O”, which

The study was not sponsored.

enables registration of 135 symptoms from the areas of experiencing, somatic functions and behavior, as well as its shortened version, (“S”), which enables possibly quick identification of the presence of neurotic disorder [2]. The diagnostic criterion is the value of the Global Symptom Level (OWK), resulting from the summation of the points assigned to the answers identifying the occurrence and the intensity of a symptom: 1 = the symptom did not occur during the last week, 4 - was slightly bothersome during the last week, 5 – was modestly bothersome, 7 – was very bothersome

Specifying the limit above which the values of the Global Symptom Levels (OWK) occur significantly more frequently in the persons with neurotic disorders than in the persons who do not suffer from the disorders, enables to identify the presence of neurotic disorder with a high probability. However, it does not allow to diagnose the type of the disorder in ICD-10 [3] or DSM-IV categories. The attempts to create scales of the symptom checklist in accordance to these categories encountered difficulties, most probably being the consequence of a little adequacy of the categories of classification with the actual picture of the disorders [2, 4].

The symptom checklist “O”, which allows possibly comprehensive description of the syndrome of neurotic symptoms, (138 items, therein three repeated in order to assess the truthfulness of filing in the symptom checklist) – has been successfully used for years in both diagnostics as well as in assessing the fluctuations of the symptoms’ intensity, resulting, for instance, from the treatment. However, it is too expanded to be used for quick assessment such as in screening, in epidemiological studies etc. For these purposes the symptom checklist „S” has been prepared, the consecutive variants of which have been published in the years 1981 and 2000 [5,6]. It has been assumed that the items included in the symptom checklist, which aims at differentiating persons with neurotic disorders from the examined population, should reflect the currently most common types of dysfunctions. Because the frequency of occurrence of particular symptoms, composing the picture of the neurotic disorder changes periodically, most probably as a result of the modifications of socio-cultural factors [7,8,9], there is a need to design new variants of such tools

every few years. For this reason the construction of the symptom checklist S-II has been based on the studies which examined the frequency of particular symptoms occurrence in the group of patients treated in the years 1996-1999 [8], while the symptom checklist S-III – of the patients treated in the years 2005-2008.

Material and methods

The items concerning the most frequently occurring symptoms have been selected on the basis of the analysis of the symptom checklist "O", which were filled in during the process of diagnosis, preceding the admission to psychotherapy, performed in the outpatient clinic and on the daily ward of the Krakow University Hospital, both connected with the Department of Psychotherapy, CM UJ and dealing with treatment of neurotic and personality disorders.

Out of 2167 symptom checklists, completed by 1506 females and 661 males in the years 2005-2008, 1872 have been selected (1287 completed by females, and 585 completed by males), in which the value of the Global Symptoms Level (OWK)[1] confirmed the diagnosis of neurotic disorders, and the frequency of declared occurrence of each of the 135 symptoms has been specified in the week preceding the examination.

Two criteria has been taken into consideration in the selection of the items: declaration of the occurrence of symptoms by at least half of the examined groups of females and males, and the frequency of their highest possible intensity (marked on the Likert-type scale, namely 0-a-b-c, answer "c" - indicating very significant nuisance of the symptom). It has been specified experimentally, in a pilot studies, that the symptom should be taken into consideration if at least 36,3% of the examined population informs about its significant intensification (answer „c").

Comparing the results of the analyses of frequency of the symptoms' occurrences in the population of patients who came for treatment because of neurotic disorders in the years 1996-1999 and 2005-2008 has revealed that in the period 2005-2008 less frequently than in the previous period

[1] OWK above 200 points in females, and above 165 points in males.

(in less than 50% of the population) occurred seven of the symptoms. These were mainly somatic ailments (“excessive thirst or appetite”, „unspecified, migrating pains”, “disorders of balance”, “unpleasant feelings or pains arousing under the influence of noise, bright light, delicate touch”), and hypochondriacal disposition (“feelings of suffering from some serious diseases that threatens your life”), as well as sexual dysfunctions (difficulties in sexual life because of - for example, pain or contraction of muscles in women, or lack of erection or early ejaculation in men, and so on) and “decrease of sexual potency”. On the other hand, eight other symptoms occurred more frequently: obsessions-compulsions (“blasphemous, immoral thoughts and ideas”, “the need to repeat unnecessarily some activities”); “difficulties in relations with persons of the opposite sex”; “feeling as if the world was in a fog”, “daydreaming”, and among the somatic ones - “reddening (blushing) on the face, neck, or chest; “nausea”, and “abdominal distension and involuntary passing of gas”.

Among 82 items included in the symptom checklist S-III, 69 concerns the symptoms which were identified in at least 50% (up to 99%) of patients in both males and females subgroups (usually slightly more often in females, but 14 of them occurred more often in males than in females), 10 symptoms, the frequency of which exceeded 50% only in the female subgroup, and 3 – only in the male subgroup. The differences in the frequency of symptoms between males and females exceeded 5%, the most prominent difference – over 40% - was found in the case of the tendency to cry (more often occurring in females). For one of the items the decisive criterion was the significant intensification of the symptom, at the frequency of its identification in only 48%.

Five items have been repeated in the symptom checklist (pairs no. 2-52 - feeling of annoying internal tensions, no. 8-35 - checking repeatedly in a bothersome way whether everything has been done correctly (the door locked, the oven turned off, etc.); no. 11-75 - choking in the throat, feeling of a "lump in the throat”, no. 15-80 – fast, strong heartbeats (palpitations) not caused by any physical activity; and no. 16-67 – feeling of sadness, gloom) to form the “truthfulness scale” that can detect accidental choosing of answers. The concordance of answers in occurrence and intensity of the symptom proves credibility of the information. It has been assumed that the unreliability of

filling in of the symptom checklist can be suspected in case of lack of concordance in stating the occurrence of a given symptom and such a difference (in one item the answer – 0, in the other – “a”, “b” or “c”) has been estimated as 5 points, while the difference in the assessment of intensity of the symptom exceeding one grade has been estimated as 1 point, two grades (slightly bothersome – very bothersome) – as 3 points. The result on the scale exceeding 12 has been assumed to be an evidence of a high probability of a low truthfulness of the symptom checklist completion.

Normalization of the symptom checklist

The symptom checklists used in the studies have been completed by the persons who came for therapy and were diagnosed in the neurotic and personality disorders outpatient clinic of the Krakow University Hospital in the years 2009-2010. The control group was composed mostly of 4th year medical students as well as participants of psychotherapy postgraduate studies and of other training courses provided by the Department of Psychotherapy CM UJ.

Results

The reliability of the symptom checklist has been assessed on the basis of the study carried out in the group of 508 patients and 301 untreated persons. The Cronbach’s alpha coefficient for the group of patients was 0,97 (in general and in both males and females groups), the Guttman's split-half reliability coefficient was 0,93 (0,94 for females and 0,92 for males).

The mean value of the Global Symptom Level (OWK) for the Symptom checklist S-III in the population of 508 persons (361 females and 147 males), who were treated because of neurotic disorders and/or specific personality disorders, amounted to 293 points for females and 259 points for males (statistically significant difference $p<0,0001$), standard deviation: 114 points for females and 119 points for males, medians consecutively 291 points and 258 points, minimal values: 42 points and 10 points, and maximal: 573 points and 512 points, lower quartiles: 206 points and 168 points, upper quartiles: 376 points and 349 points). In the population of 301 untreated persons (227 females and 74 males) the mean value was 89 points for females and 87 points for males (statistically not significant difference $p>0,05$), standard deviation: 62 points for females and 61 points for males, medians consecutively 75 points and 66 points, minimal values: 0 points and 8

points, maximal: 391 points and 267 points, lower quartiles: 44 points and 42 points; upper quartiles 115 points and 125 points).

Normal ranges

By means of the method of optimization of the cutoff point it has been indicated that in the population of 361 females, who came for therapy, and 227 untreated ones, at the value of Global Symptom Level (OWK) = 146/147 points, the values are higher in 89,5% of the ill persons and lower in 86,4% of untreated persons from the set limit. In the population of 147 males who came for therapy and 74 untreated ones, at the value of Global Symptom Level (OWK) = 145/146 points the values are higher in 78,4% of the ill persons and lower in 86,5% of untreated persons from the set limit.

After the elimination of the symptom checklists, in which the scale of trustfulness exceeded 12 points, the calculations have been repeated for slightly smaller population – 354 females (98%) coming for therapy and 226 (96%) untreated ones. In this comparison, for the value of 146/147 points, 89,3% of females who came for therapy obtained higher result, and 87,2% of females form the control group – lower result from the value. In the population of 147 (100%) males coming for therapy and 70 (95%) untreated ones, whose value of the truthfulness scale did not exceed 12 points, at the value of 145 and 146 points – in 78,4% of the ill persons the values of OWK were higher, and in 87,1% untreated – lower, from the set limit.

It has turned out, however, that such rule of elimination of the unreliably completed symptom checklists rises some doubts. In spite of the result below 12 points on the truthfulness scale, in the symptom checklists of many persons differences have appeared between the answers indicating the absence of a given symptom and confirmation of its presence in another question concerning the same symptom. Such situations were found more often in the control group (54% males, 49% females), than in the group of patients (43% males, 34% females). Elimination of such symptom checklists from the female population has not changed the indications for the optimal cutoff point, in the male population it has practically precluded its assessment.

Correlations were also estimated between the symptom checklist S-III results and: the symptom checklist "O" (p<0,0005) (the symptom checklist "S" includes circa 2/3 of the pool of items from the symptom checklist "O"); the Social Avoidance and Distress Scale (SAD) – 0,35 (p<0,0005); Fear of Negative Evaluation Scale (FNE) – 0,30 (p<0,0005). The last two questioners have been completed by 208 persons from the same population of the ill persons.

Conclusions and discussion

Taking into consideration the results of analyses presented above, it has been justified to assume that the threshold value of the OWK = 146 points, regardless of the gender of the examined persons, properly differentiates the results of the checklists of the persons suffering from neurotic disorders from the persons who do not suffer from them, preventing at the same time too rush diagnosis of the disorders. After setting the threshold, the probability of identifying a person suffering from neurotic disorders as not suffering from them is low – in an unselected population (coming for therapy mostly because of neurotic disorders, but also because of specific personality disorder, eating disorders, etc.), only in about 10% of females and about 21% of males the OWK values were lower from the threshold.

In the females and males populations the frequency of occurrence of neurotic symptoms is similar, and it seems that at present even more than in the years 1996-1999. In the previous period only 48 symptoms (out of 81) occurred with equal frequency in both subgroups, at present – as many as 69 out of 82. It may prove the disappearance of the qualitative, gender dependent, differences of the clinical picture of neurotic disorders. Only two of the symptoms – tendency to cry and nausea – occurred considerably (over 20%) more often in the female subgroup, and one of them – blasphemous, immoral thoughts and ideas – more frequently in males. It seems that it can be connected with progressive in the recent years change in the specificity of women's functioning in their social role, manifesting in undertaking by them the roles traditionally ascribed to men. It can be assumed that – analogically to the way of functioning – also the kind of experiences connected with the functioning (for example conflicts), expressed by means of neurotic symptoms, is more and

more similar for females and males. However, like in other studies, the Global Symptoms Level (OWK), turned out to be higher for females than for males.

The relatively low reliability of filling in of the symptom checklist seems to be surprising, calling into question the rules of assessment based on the prepared scale. The frequency of exceeding the range of 12 points turned out to be low (about 5% of the population), while disparate answers concerning noticing or not-noticing the occurrence of a symptom in one of the repeated pairs of items has been found in 30 – 50% of symptom checklists. Such inconsistencies appeared more frequently in the groups of untreated persons than in the groups of persons coming for therapy, which seems to be connected with different motivation to fulfill the symptom checklist thoroughly, but also indicates significant possibility of incorrect interpretation of the tests' results of the persons coming for therapy. It may be suggested that the criterion of treating the symptom checklist as unreliably completed should be first of all finding at least one difference in the answer concerning noticing or not-noticing the occurrence of a symptom. The difference in assessing the intensity of the symptoms should also be taken into consideration, as it also indicates limited trustfulness of the answers, and thus – the information about the presence (or absence) of neurotic disorder, resulting from the OWK value.

The normal range for the symptom checklist S-III (cutoff point) is located on a significantly lower level (146 points) than in the case of the symptom checklist S-II (165). It cannot be explained by the relation between the value of OWK and the amount of items, especially that the symptom checklist S-III consists of more items (one more) than S-II. It also cannot be explained by the difference in the size of the groups - although indeed in the study carried out in the years 1999-2000 the population of untreated females numbered only 89, males 61 (at present 361 females and 147 males), but it is difficult to assume that this is the reason of such substantial difference in the cutoff points. Perhaps, in the years 2005-2008, the people came for therapy with less severe symptom intensity than in the years 1996-1998. This could mean reduction of difficulties and apprehensions related to the consequences of making decision to undertake treatment.

The proportion of the people coming for therapy who had the level of OWK lower than 146 points, and the untreated people who had the value of the indicator above 146 points, requires reflection. In the previous populations of persons coming for therapy, the vast majority suffered from neurotic disorders. Some of the patients who first of all had personality disorders diagnosed, had few such symptoms during testing (however, while they were in treatment, many of them experienced considerate aggravation of neurotic symptoms). It was decided to resign from excluding these ill persons from the study group because the inaccurateness of diagnoses formulated in the categories of ICD-10 classification. Most likely for this reason the results of the OWK were lower than 146 points in 10% of females and 21% of males, who came for therapy only because of personality disorders.

The data mentioned above differ from those obtained in the process of normalization of the symptom checklist S-II, five years ago. In the population of persons coming for treatment, about 12% of females and 13 % of males had lower results than 165 points. It may lead to the assumption that at present more frequently come for treatment males suffering from personality disorders and other functional disorders without any neurotic symptoms. The increase from 13% to 20% can of course be accidental, however, it is in accordance with the clinical observations. On the other hand, the persons from the untreated population, whose OWK indicator exceeded 146 points, representing up to 14% of these groups – are most probably the persons suffering from neurotic disorders. As it is known from clinical studies, the proportion of people from urban populations suffering from neurotic disorders ranges within these limits [11, 12, 13].

So there are no grounds to assume that the frequency of neurotic disorders in the untreated population has changed within the last 10 years which have passed between the studies. However, it seems that the clinical picture of the disorders has changed. Somatic and sexual dysfunctions are more and more frequently replaced by obsessions-compulsions (especially “blasphemous, immoral thoughts and ideas”) and “difficulties in relations with persons of the opposite sex”, as well as the symptoms of derealization. It may be related to the increase of social acceptance of various sexual

behaviors, alongside with the considerable resistance (for instance of the Church) towards such cultural trends. Nevertheless, the phenomenon – just as the increase of the frequency of the symptoms of derealization and of the three specific somatic dysfunctions (reddening (blushing) on the face, neck, or chest; “nausea”; and “abdominal distension, involuntary passing of gas”) - requires separate prospecting and interpretive analyzes.

It was decided to resign, while constricting the symptom checklist S-III, from the scale formation, and especially from seeking the possibilities to form scales that would correspond with categories of neurotic disorders listed in ICD-10. The analysis of the answers for the items of the symptom checklists reveals that most of the respondents perceive the aliments connected with various symptoms of neurotic disorders listed in the classifications. Similar, confirmed in other studies, values of the correlation coefficients of frequency of occurrence of most of the dysfunctions described by the items of the “O” and “S” symptom checklists are the reason why the taxonomic divisions and factor analyses lead to doubtful conclusions. The everyday clinical experiences incline to the conviction that the use of such scales leads to deformation of the clinical picture and to tailor it to the definitions used by the system of classification.

It is most likely that the construction of separate categories of “disorders”, based on complexes of symptoms, results to some extent from the fact that the patients reveal during the direct diagnostic contact only some of their aliments, not necessarily the most bothersome ones. As it seems, some of the expectations of the diagnostician can be relevant in some way – the patient, convinced that he is examined by a doctor, presents different of his symptoms than when he thinks he is examined by a psychologist. Another reason is the knowledge of the examined persons about the existence and the picture of the disorders, unknowingly they tend to present them according to their knowledge.

The obligation to formulate such diagnosis forces the diagnosticians to omit in the patients’ descriptions many symptoms that do not fit in the criteria of the “disorder”, or to construct diagnoses combining the names of many categories. Commonly adopted solution of the difficulty in

diagnosing neurotic disorders has become preferring to diagnose personality disorders (especially "unspecified") and to omit possible diagnosis of neurotic disorder. Such solution seems to be especially harmful, as it diverts attention of the therapists from the neurotic symptoms, which in fact may be the key to understand the essence of the dysfunction. What is more, it makes the impression of more frequent occurrence and treatment of personality disorders.

Another, commonly used solution, is assuming co-occurrence of few various neurotic disorders in one patient. This leads to treating the disorders as if they were separate nosological entities, and not nosographic constructs, and – in the case of pharmacotherapy – using drugs considered to be useless in these disorders.

For that reason is appears to be more reasonable to pay greater attention to stating the presence of neurotic disorder rather than to the diagnosis of type of the disorder in the ICD-10 categories and resignation from attempting to constructs scales that would confirm such diagnosis.

Additional impediment of using the diagnostic categories is the substantial changeability of the clinical picture of patients with neurotic disorders, probably connected with the modifications of the kinds of pathogenic socio-cultural factors. This is one of the reasons of the necessity to introduce changes relatively often into the system of classification and terminology, namely the conviction about vanishing some of them and increasing frequency of other types of disorders.

The changes within a given complex of symptoms are a frequently observed effect of psychotherapy (as a result of such impact, the initial diagnosis may be considerably different form the diagnosis during treatment, and the more after its termination – which surprises especially in case of lack of improvement). However, it turns out that already in the period of awaiting for the beginning of therapy, substantial instability of the syndrome of neurotic disorder may be observed. Its changeability reaches 50% of the symptoms' occurrence, reported in the first of two subsequent measurements performed before treatment.

The phenomenon of changeability of the symptoms of neurotic disorders prompts cautious interpretation of the results obtained by means of symptom checklists. One of the main conclusions

from the presented studies seems to be the recommendation of frequent (every 5-6 years) reconstruction of the symptom checklists which serve the aims of selection in epidemiological studies and fast diagnosis of neurotic disorders (for instance in the primary health care). The symptom checklist S-III will fulfill the task only for the next few years.

References

1. Derogatis LR, Melisaratos N. The Brief Symptom Inventory: An introductory report. Psychol. Med. 1983; 13: 595–605.
2. Aleksandrowicz JW, Bierzyński K, Filipiak J, Kowalczyk E, Martyniak J, Mazoń S, Meus J, Niwicki J, Paluchowski J, Pytko A, Romeyko A. Kwestionariusze objawowe S i O – narzędzia służące do diagnozy i opisu zaburzeń nerwicowych. Psychoter. 1981; 37: 11–27.
3. ICD-10. Klasyfikacja zaburzeń psychicznych i zaburzeń zachowania. Kryteria badawczo-diagnostyczne. Kraków–Warszawa: UWM Vesalius, IPiN; 1998.
4. Rewer A. Skale kwestionariusza objawowego „O”. Psychiatr. Pol. 2000; 34, 6: 931–943.
5. Aleksandrowicz JW, Hamuda G. Kwestionariusze objawowe w diagnozie i badaniach epidemiologicznych zaburzeń nerwicowych. Psychiatr. Pol. 1994; 28: 667–676.
6. Aleksandrowicz JW. Kwestionariusz S-II. Psychiatr. Pol. 2000, 34, 6: 945–959.
7. Aleksandrowicz JW, Świątek L. Częstość występowania zaburzeń nerwicowych. Psychoterapia. 1985; 3: 21–26.
8. Aleksandrowicz JW. Częstość objawów nerwicowych. Psychiatr. Pol. 2000; 34: 5–20.
9. Aleksandrowicz JW. Zmiany częstości występowania zaburzeń nerwicowych. Psychiatr. Pol. 2001; 35, 3: 351–377.
10. Aleksandrowicz JW. Psychoterapia. Warszawa: PZWL; 2000.
11. Kiejna A, Wojtyniak B, Rabczenko D, Szewczuk-Bogusławska M, Trypka E, Łupiński P. Samopoczucie ludności Polski w badaniu przeprowadzonym przez Główny Urząd Statystyczny – analiza wstępna. Psychiatr. Pol. 2000; 34: 21–34.
12. Schepank H. Epidemiology of psychogenic disorders. Berlin-Heidelberg: Springer-Verlag; 1987.
13. Aleksandrowicz JW. Epidemiologia zaburzeń nerwicowych. W: Epidemiologia zaburzeń psychicznych, red. A. Kiejna, J. Rymaszewska. Biblioteka Psychiatrii Polskiej. Kraków: KRW PTP; 2003, 89–102.
14. Sobański JA, Klasa K. Zmiany nasilenia objawów w okresie oczekiwania na leczenie. Psychoter. 2005; 132, 1: 67–79.

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SYMPTOM CHECKLIST S-III

ITEMS OF THE SYMPTOM CHECKLIST

(instruction)

if the symptom did not occur during the last week	indicate "0"
if the symptom occurred, but was slightly bothersome during the last week	indicate "a"
if the symptom was modestly bothersome	indicate "b"
if the symptom was very bothersome	indicate "c"

1.	feelings of fatigue and weakness in the morning that subsides during the day	0 a b c
2.	feeling of annoying internal tension	0 a b c
3.	persistent feeling of anxiety without any reason	0 a b c
4.	frequent crying	0 a b c
5.	memory impairment	0 a b c
6.	dissatisfaction with sexual life	0 a b c
7.	feelings of discomfort in large groups	0 a b c
8.	checking repeatedly in a bothersome way whether everything has been done correctly (the door locked, the oven turned off, etc.)	0 a b c
9.	dizziness	0 a b c
10.	lack of self-dependence	0 a b c
11.	choking in the throat, feeling of a "lump in the throat"	0 a b c
12.	finding in oneself signs of various serious diseases	0 a b c
13.	compulsive, bothersome, persistent thoughts, words or fantasies	0 a b c
14.	frightening dreams, nightmares	0 a b c
15.	fast, strong heartbeats (palpitations) not caused by any physical activity	0 a b c
16.	feeling of sadness, gloom	0 a b c
17.	anxiety or/and other unpleasant sensations constantly occurring whenever staying alone, for example in an empty house, etc.	0 a b c
18.	strong feeling of guilt, blaming oneself	0 a b c
19.	paralyzing, inexplicable anxiety preventing any kind of activity	0 a b c

20.	strong heartbeats (palpitations) without any physical activity	0 a b c
21.	headaches hindering activities	0 a b c
22.	bothering feeling of not having anyone really close	0 a b c
23.	feeling of flushes of blood into the head	0 a b c
24.	lack of self-confidence which makes everyday life more difficult	0 a b c
25.	absent-mindedness which hinders acting	0 a b c
26.	absorbing ritualistic actions performed to prevent disease	0 a b c
27.	reddening (blushing) on the face, neck	0 a b c
28.	difficulties in falling asleep	0 a b c
29.	heart pain	0 a b c
30.	apprehension	0 a b c
31.	experiencing emotions strongly and deeply	0 a b c
32.	feeling that thinking is more difficult and not as clear as usually	0 a b c
33.	dryness of the mouth	0 a b c
34.	avoiding people, even the close ones	0 a b c
35.	checking repeatedly in a bothersome way whether everything has been done correctly (the door locked, the oven turned off, etc.)	0 a b c
36.	awkwardness, life helplessness	0 a b c
37.	attacks of panic terror	0 a b c
38.	nervousness, chaos in movements, decreasing efficiency of acting	0 a b c
39.	constant paying attention to body functions – for instance heart rate, pulse, digestion	0 a b c
40.	loss of faith in one's own strength	0 a b c
41.	inability to restrain from expressing one's own emotions regardless of the consequences	0 a b c
42.	difficulties in concentration, paying attention	0 a b c
43.	significant decrease or lost of sexual potency	0 a b c
44.	deceleration (slowing down) of movements and thoughts, apathy	0 a b c

45.	feeling of being worse than others	0 a b c
46.	fears about one's own health and about becoming seriously ill	0 a b c
47.	frequent awakening at night	0 a b c
48.	feeling of anxiety in crowds	0 a b c
49.	pessimism, expecting failures or disasters in the future	0 a b c
50.	constant feeling of fatigue	0 a b c
51.	feeling of being endangered without any reason	0 a b c
52.	feeling of annoying internal tension	0 a b c
53.	trembling of legs, hands, or of the whole body	0 a b c
54.	feeling of being easily influenced by others	0 a b c
55.	uncontrolled outbursts of anger, hostility	0 a b c
56.	blasphemous, immoral thoughts and ideas	0 a b c
57.	ssleeplessness	0 a b c
58.	feelings of heat and/or cold without reasons	0 a b c
59.	lack of strength and energy in any kind of activity	0 a b c
60.	difficulties in breathing - for example, breathlessness - that appears and subsides after a while	0 a b c
61.	feeling of apprehension, stage-fright, before some meetings, events, etc.	0 a b c
62.	feeling of not being appreciated by anyone	0 a b c
63.	slowing down of thinking, loss of acuity	0 a b c
64.	abdominal distension and involuntary passing of gas	0 a b c
65.	feeling that people have a hostile attitude towards you	0 a b c
66.	feeling as if the world was in a fog	0 a b c
67.	feeling of sadness, gloom	0 a b c
68.	involuntary trembling of the face, eyelids, head, or other parts of the body	0 a b c
69.	bothersome sweating in moments of nervousness	0 a b c
70.	feeling of being easily influenced by others, of submitting to others	0 a b c
71.	constant feeling of anger and hostility	0 a b c

72.	nausea	0 a b c
73.	immersing in daydreams	0 a b c
74.	anxiety that something terrible will happen or that you will do something terrible, for instance jumping out of window, or that a disaster will occur	0 a b c
75.	choking in the throat, feeling of a "lump in the throat”	0 a b c
76.	difficulties in relations with persons of the opposite sex	0 a b c
77.	feeling of rebelliousness	0 a b c
78.	feeling of sleepiness which forces to doze no matter of circumstances	0 a b c
79.	worries about the people close to you, in spite of no real danger	0 a b c
80.	fast, strong heartbeats (palpitations) not caused by any physical activity	0 a b c
81.	feeling that people do not care about you and your problems	0 a b c
82.	accumulation of thoughts	0 a b c
83.	feeling of tension in the muscles	0 a b c
84.	need of loneliness	0 a b c
85.	muscle pains – for instance in a lower back, in the chest, etc.	0 a b c
86.	the need to repeat actions unnecessarily	0 a b c
87.	lack of appetite	0 a b c