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THE COMPARISON BETWEEN PERSONALITY CHARACTERISTICS AND FAMILY RELATIONS OF THE SUBJECTS WITH NEUROTIC LEVEL OF PERSONALITY ORGANIZATION WITH CONTROL GROUP

NEVROTİK ORGANİZASYONLU BİREYLERİN KİŞİLİK ÖZELLİKLERİNİN VE AİLE İLİŞKİLERİNİN KONTROL GRUBUNA GÖRE KIYASLANMASI

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Abstract

Studies to explain neurotic personality organization is no more. Studies emphasize the early family relationships are important in formation of this structure. Our study aims to assess personality traits and family relations of individuals with neurotic personality organization. 31 patients assessed in neurotic personality organization according to SCID-I and SCID-II followed by social psychiatry unit (Structured Clinical Interview for DSM Disorders), 31 control groups not taking diagnostic in the same tests were included in study. Socio-demographic data form was filled by interviewer, Beck Depression Inventory, MMPI (Minnesota Multiphasic Personality Inventory), State-Trait Anxiety Inventory, Family Assessment Scale, Sheehan Disability Scale by the participants. Control group was created from, of volunteers, subjects not taking any psychiatric diagnosis. Compared to neurotic patient group with control group; Shehan Disability Scale for Beck Depression Inventory scores; Family Assessment Scale for social life and family environment, business subscale and household responsibilities, for State-Trait Anxiety Inventory; hypochondria, depression, hysteria, and social introversion subscales for problem solving and behavior control subscale scores between groups and Minnesota Multiphasic Personality Inventory. Neurotic group was taking significantly diagnosis compared to control group for depressive disorder, anxiety disorders and avoidant personality disorder. Considered that avoidant personality structuring of neurotic individuals are at the forefront, the secondary anxiety and depressive symptoms progress. Said all these processes impair domestic problem-solving, behavior control skills of these individuals. Supports this process that the average score of neurotic patients are higher than control group for hypochondria, depression, hysteria, and social introversion subscales as results of MMPI.

Keywords: Neurotic organization, personality characteristics, family interaction.

Özet

Çalışmamız nevrotik kişilik organizasyonu olan bireylerin kişilik özellikleri ve aile ilişkilerini değerlendirmeyi hedeflemektedir. Çalışmaya, sosyal psikiyatri biriminden takipli SCID-I (Structured clinical interview for DSM disorders) ve SCID-II' ye göre nevrotik kişilik örgütlenmesi içinde değerlendirilen 31 hasta ve 31 kontrol gurubu alındı. Kontrol grubu rastlantısal bir şekilde, gönüllüler arasından, psikiyatrik açıdan herhangi bir tanı almayan deneklerden oluşturuldu. Sosyodemografik Veri Formu görüşmeci tarafından, Beck Depresyon Ölçeği, MMPI (Minnesota Multiphasic Personality Inventory), Durumluk-Sürekli kaygı Envanteri, Aile Değerlendirme Ölçeği, Sheehan Yeti Yitimi Ölçeği çalışmaya katılanlar tarafından dolduruldu. Nevrotik hasta gurubunun kontrol gurubuna göre; Beck Depresyon Ölçeği puanları açısından, Shehan Yeti Yitimi Ölçeğinin; sosyal yaşam ve aile ortamı, iş alt ölçeği ve evdeki sorumluluklar açısından, Durumluk-Sürekli Kaygı Envanteri açısından, Aile Değerlendirme Ölçeğinin; gruplar arasında problem çözme ve davranış kontrolü alt ölçekleri ve Minnesota Çok Yönlü Kişilik Envanteri açısından; hipokondri, depresyon, histeri ve sosyal içe dönüklük alt ölçekleri anlamı bulundu. Çalışmada nevrotik grup en çok depresif bozukluklar, anksiyete bozuklukları ve kaçıngan kişilik bozukluğu açısından kontrol grubuna göre anlamlı tanı alıyordu. Nevrotik bireylerin kaçıngan kişilik yapılanmalarının daha ön planda olduğu, buna sekonder anksiyete ve depresif semptomlarının geliştiği ve bu nedenle bu bireylerin aile içi problem çözme ve davranış kontrolü yetilerinin bozduğu söylenebilir. Yine MMPI sonuçları olarak hipokondri, depresyon, histeri ve sosyal içe dönüklük alt ölçekleri açısından nevrotik hasta grubunun ortalama puanları kontrol grubundan anlamlı olarak yüksek olması bu süreci desteklemektedir.

Anahtar Kelimeler: Nevrotik organizasyon, kişilik özellikleri, aile ilişkileri

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1. Introduction

Mental structure according to the dynamic theory; can be seen in three different ways, as psychotic organization, borderline personality organization and neurotic personality organization. There are not much studies conducted to explain neurotic and borderline personality organization. The studies emphasize on the formation of these structures that early family relationships are of great importance. According to Kernberg spiritual organization can be seen in three ways (Kernberg, 1997), these are; Neurotic personality organization, borderline personality organization, psychotic personality organization.

According to Kernberg, the distinction between these organizations is performed based on three qualities including identity integration, defense mechanisms, and reality testing

In the neurotic personality organization; it is distinguished from other personality organization with being full of identity integration, being high level defense mechanisms and being full of reality testing. A sufficient anxiety tolerance, impulse control and sublimation capacity is observed in neurotic organization.

All self-image in the neurotic structure (both good and bad ones) is integrated to a comprehensive self and also "good" and "bad" image of others is integrated to the concept of a comprehensive others. People have a solid sense of self and the capacity to thoroughly understand others. The capacity that Neurotic person has to live in ''all'' object relations, reflects the integration of the contrasting properties related to both its own and the others.

In the neurotic person, ego defense organization generates advanced or high level defense mechanisms such as reaction formation, isolation, making-breaking, intellectualization and rationalization especially repression. Urges not approved through these defense mechanisms are removed from the conscious ego and thus the ego would be protected from intrapsychic conflicts (Kernberg, 1997).

According to Hornet, neurosis; does not completely separate from the community generally people living within a certain community, and is the behavioral disorders affecting adversely people's health, efficiency and effectiveness. Neurosis arises from a socio-psychic conflict; and the disorders and the conflicts in human relations. They are important determinants socio-cultural factors in the formation of neurosis for which human relationships vary according to specific communities and cultures (Horney, 1993).

Neurosis is a mental disorder that the basic disorder is a symptom or group of symptoms afflicting people. These symptoms are defined as unacceptable by person and foreign ego (ego-dystonic); reality testing is largely preserved. Behavior does not create significant impairment in social dimensions. The disorder is more than just a temporary react against the stress factors and shows a chronic and recurrent course to the extent that it is not treated. (Kaplan&Sadock, 2007).

2. Material and Methods

The Study was conducted Istanbul University Faculty of Medicine Department of Psychiatry in Social Psychiatry Unit.

31 patients followed by social psychiatry unit and evaluated in the neurotic personality organization according to SCID-I (Structured clinical interview for DSM-III-R) and SCID-II were included in the study. In addition, 31 healthy controls attempted to be compatible with the patient group in terms of age, gender and education were included in the study. In order to determine the healthy control group, SCID-I and SCID-II tests were applied to this person. The control group did not receive any diagnostic from these tests. Thus, 31 healthy control groups were created.

After people were informed about the study and their written approvals were obtained, two interviews were planned with people in the patient and control groups. During the first interview, Sociodemographic data form by the interviewer and Beck Depression Scale, MMPI (Minnesota Multiphasic Personality Inventory), State- Trait Anxiety Inventory, Family Assessment Scale, Sheehan Disability Scale were filled by the study participants. At the first interview, SCID-I form was given after applying SCID-II and at the second interview, SCID-II was performed.

It was defined as inclusion criteria in patients with the condition of being at least primary school graduates, being at least 18 years, responding to the tests to be applied, taking diagnosis of SCID-I in the neurotic personality organization. The exclusion criteria; was determined as taking diagnosis of SCID-II (except for cluster C) alcohol, substance abuse or addiction, bipolar disorder, psychotic disorders, depressive disorders other than depressive disorders developing depending on neurotic conflicts from diagnosis of SCID, psychiatric disorders due to general medical condition or substance use. The control group was created of subjects without taking any psychiatric diagnosis among from volunteers in a random way. It was tried to be consistent in terms of age, sex and education with patient group.

The obtained data was entered into the computer by using SPSS 11.0 for Windows program, Kolmogorov Smirnov test was used to determine the distribution of the variables and normally distributed variables were evaluated using in dependent t-test while Mann Whitney U test was used in evaluation of the abnormally distributed variables. The qualitative data were compared using Yates Continuity Correction Test. There results were evaluated by accepted significance level of $p<0,05$.

All participants gave a written informed consent and the Local Ethics Committee approval was obtained for the study.

The tests we used in this study;

2.1. SCID-I: According to DSM-III-R classification is a method of the structured interviews applied individually to diagnose on 1st axis (Spitzer et al., 1987). Validity and reliability studies were conducted in Turkey (Sorias et al., 1988).

2.2. SCID-II; is personality disorder screening test structured according to DSM-III-R consisting of 120 questions and conduct disorder additional section (Spitzer et al., 1990). The validity and reliability studies were conducted in Turkey (Sorias, 1990).

2.3. Socio-demographic Data Form; is the version prepared by Istanbul University, Istanbul Faculty of Medicine, Department of Psychiatry, Social Psychiatry Service Team and revised by being shortened Social Psychiatry Service Application Evaluation Form. It was administered by an interviewer.

2.4. State-Trait Anxiety Inventory (STAI); was developed to determine state and trait anxiety levels (Spielberger et al., 1970). STAI is a self-assessment questionnaire containing two scales composed of a total of 40 articles. The reliability and validity studies were conducted in Turkey (Öner, 1994) It can be considered that anxiety level has exceeded the normal limits on the values of 60 or above.

2.5. Beck Depression Scale; is a self-assessment questionnaire used to measure emotional, somatic, cognitive, and motivational symptoms seen in depression (Beck et al., 1961). It was stated that the cut-off point of the scale is 17 in reliability and validity article for Turkish. The adaptation and validity and reliability of the scale was made in Turkey (Tegin, 1980).

2.6. Family Assessment Scale (FAS); This scale has been defined to distinguish healthy and unhealthy the structural and organizational features of the family and the interaction between family members. The validity and reliability study of the scale was conducted in our country. (Bulut, 1990).

2.7. Shehan Disability Scale (SDS); a scale developed to measure the life quality (Leon et al., 1995). Disability is measured with three items. (work, social life and leisure pursuits, family life and household responsibilities). In each item, 0-10 [no [0] light [1, 2, 3], medium [4, 5, 6], evident [7, 8, 9] and excessive [10]) assessment point is given. Total scores range varies between 0-30.

2.8. MMPI (Minnesota Multiphasic Personality Inventory); was used for the first time in 1943, created by the University of Minnesota. It is an objective personality inventory developed by Psychologist Stark R. Hathawey and Neuropsychiatrist J. Charnley Mc Kinley. Turkish adaptation and standardization was made. (Savaşır, 1981). Profiles were rearranged according to Turkish standards and neurotic and psychotic patient norm profiles were performed as well as the normal male and female profiles by making the validity research on psychiatric patients.

3. Results

The ages of 62 people included in the study (31 patients and 31 Control Group) were between 18 and 43. The mean age of the control group was 25.59 and the mean age of the patient group was 26.35. The average number of siblings in the patient group was 2.61. The average number of siblings in the control group 3.90 ± 2.28 was found statistically significantly higher than the study group 2.61±1.05. The average place in sibling order of the patient group was 1.84. The average place in sibling order of the control group was 2.58. There was a significant difference between groups (see Table 1).

Table 1:

	Neurotic Group(N=31)	Control Group(N=31)	P
Sociodemographic data			
Gender (Female)	21 (67,70%)	20 (64,52%)	[a]0,998
Age	26,35±7,16	26,39±6,06	[b]0,981
Education level			
Uneducated	0	0	
Primary-secondary school/High school	22 (71,00%)	20 (64,52%)	
University	9 (29,00%)	11 (35,48%)	[a]0,785
Marital status			
Single	22 (71,00%)	25 (80,60%)	[a]0,554
Married/shacking	9 (29,00%)	6 (19,40%)	
Mean number of siblings	2,61±1,05	3,90±2,28	[c]0,005
Mean birth order among siblings	1,84±0,89	2,58±1,80	[c]0,044

[a]YatesContinuity Correction Test
[b]Independent-t Test
[c]MannWhitney U Test

In terms of SCID-I and SCID-II features, there were significant differences in terms of whether the current and past major depressive episodes, panic disorder (agoraphobia or without agoraphobia), social phobia, anxiety disorder not otherwise specified (NOS), undifferentiated somatoform disorder, avoidant personality disorder, any SCID-I or SCID-II diagnosis were taken between patient and control group.

Between women of both groups; there were significant differences in terms of whether the current and past major depressive episodes, undifferentiated somatoform disorder, avoidant personality disorder, or any SCID-I, SCID-II diagnosis were taken.

Table 2:

	Neurotic Group (N=31)	Control Group (N=31)
SCID-I		
Between groups; current and past		
M. Depressive episode (current)	7	0
M. Depressive episode (past)	16	0
Panic disorder	6	0
Social phobia	6	0
Anxiety disorder NOS	7	0
Undifferentiated somatoform disorder	6	0
Whether diagnosed any SCID-I disorder	31	0
Between female subjects of both groups; current and past		
M. Depressive episode (current)	6	0
M. Depressive episode (past)	10	0
Undifferentiated somatoform disorder	6	0
Whether there was any diagnosis of SCID-II	21	0
Between male subjects of both groups; past		
M.depressive episode (past)	6	0
Whether diagnosed any SCID-I disorder	10	0
SCID-II		
Between groups; current and past		
Avoidant personality disorder	7	0
Between female subjects of both groups; current and past		
Avoidant personality disorder	5	0

Between men of both groups; there were significant differences in terms of whether the current and past major depressive episodes, any SCID-I, SCID-II diagnosis were taken.

Statistic analysis was not made in these parameters, because it was necessary that these diseases were not available in the control group. Therefore we only specified the differences in the patient group.

In terms of Beck depression scale, the average score of the patient group was 14.45 (indicates mild depression) and it were statistically significantly higher than the control group 4.94. (points to a value below major depression).

Compared to female patients and control group: an average score of female patients in the study group; 13.95, was statistically significantly higher than the average score of female in the control group 4.04.

Compared to male patients and control group: an average score of male patients in the patient group; 15.50, was statistically significantly higher than the average score of male in the control group 6.80.

In terms of Sheehan disability scale, the average of SDS- business subscales the patient group, the average of SDS-social life subscale, the average of SDS- family atmosphere and of the household responsibilities subscale and the total average scores were statistically significantly higher than the control group.

The average of SDS-business sub-scale of the female patient group, the average of SDS-social life subscale, the average of SDS-family atmosphere and household responsibilities subscale, SDS total average scores were statistically significantly higher than the female control group.

The average of SDS-business sub-scale of the male patient group, the average of SDS-social life subscale, the average of SDS-family atmosphere and household responsibilities subscale, SDS total average scores were statistically significantly higher than the male control group.

In terms of trait anxiety inventory, STAI- trait anxiety scores of the patient group was statistically significantly higher than the control group. Female and male STAI-Trait anxiety scores of the patient group were statistically significantly higher than the control group.

In terms of family assessment scale, problem-solving subscale of the patient group was significantly lower than the control group; the control behavior scale scores were significantly higher. While the female problem-solving subscale scores of the patient group was statistically identical than the control group, female behavior control scale scores of the patient group was statistically significantly higher than the control group.

While the male behavior control scale scores of the patient group was statistically identical than the control group, male problem-solving subscale scores of the patient group was statistically lower than the control group.

Table 3:

	Neurotic Group(N=31)	Control Group(N=31)	P
Beck depression inventory Mean scores	14,45±9,85	4,94±5,12	c0001
In female subjects	13,95±10,08	4,09±4,21	c0,001
In male subjects	15,50±9,68	6,80±6,51	c0,001
Sheehan disability scale Betweengroups			
Mean scores of work subscale	3,90±3,13	0,81±1,35	c0,0001
Mean scores of social life subscale	4,41±3,38	1,00±1,67	c0,0001
Mean scores of family life and home responsibilities subscales	3,65±3,14	0,84±1,63	c0,0001
Mean scores of whole subscales and total scores	11,71±8,54	2,65±4,11	c0,0001
Between female patients			
Mean scores of work subscale in female subjects	3,29±3,2	0,67±1,19	c0,0001
Mean scores of social life subscale in female subjects	3,48±3,34	1,14±1,85	c0,001
Mean scores of family life and home responsibilities subscales in female subjects	2,90±3,06	0,67±1,19	c0,004
Mean scores of all subscales and total scores in female subjects	9,67±7,34	2,48±4,13	c0,0001
Between male patients			
Mean scores of work subscale in male subjects	5,20±2,44	1,10±1,66	c0,0001
Mean scores of social life subscale in male subjects	5,60±3,16	0,70±1,25	c0,0001
Mean scores of family life and home responsibilities subscales in male subjects	5,20±2,86	1,20±1,93	c0,0001
Mean scores of all subscales and total scores in male subjects	16,00±7,62	3,00±4,26	c0,0001
State-Trait and Continuous anxiety inventory Mean scores (continuous anxiety scale)	46,26±14,04	36,77±10,53	c0,003
Mean female scores (continuous anxiety scale)	44,24±14,74	36,00±7,49	c0,007
Mean male scores (continuous anxiety scale)	50,50±12,03	38,40±9,57	c0,0001
Family Assessment Scale			
Problem solving subscale between groups	1,73±0,57	2,06±0,48	c0,016
Behavior control subscale between groups	2,09±0,32	1,85±0,29	c0,010
Behavior control subscale between female subjects	2,07±0,37	1,85±0,31	c0,013
Problem solving subscale between male subjects	1,67±0,76	2,25±0,35	c0,003

bIndependent-t Test   cMannWhitney U Test

In terms of Minnesota Multiphasic Personality Inventory, Hs-hypochondria, D-depression, Hy-hysteria, Si-social introversion subscale scores of the patient group were statistically significantly higher than the control group. K-advocacy subscale score was statistically significantly lower than the control group.

Table 4:

Interms of Minnesota multiphasic personality inventory	Neurotic Group(N=31)	Control Group(N=31)	P
	Mean±SD	Mean±SD	
K-defensiveness	50,03±9,36	56,81±14,01	b0,028
Hs-hypochondriasis	57,26±8,48	48,90±8,07	b0,002
D-depression	58,45±11,54	48,35±8,22	b0,002
Hy-histeria	58,45±10,28	52,52±7,73	b0,013
Si-social introversion	54,81±12,92	44,84±9,62	b0,001
Between female groups			
D-depression	56,05±10,02	46,90±6,95	b0,0001

Hs-hypochondriasis	57,24±7,95	49,19±7,15	[b]0,0001
Si-social introversion	52,00±13,46	42,43±8,68	[b]0,001
Between male groups			
K-defensiveness	45,40±8,26	54,00±13,30	[b]0,003
D-depression	63,50±13,41	51,40±10,12	[b]0,002
Si-social introversion	60,70±9,86	49,90±9,94	[b]0,0001

[b]Independent-t Test

D-depression, Hs-hypochondria and Si-social introversion scores of female patient group were significantly higher than the female control group.

D-depression, Hs-hypochondria and Si-social introversion subscale scores of male patient group were significantly higher than the female control group. K-advocacy subscale score was statistically significantly lower than the control group.

4. Discussion

There was no statistically significant difference between groups in terms of socio-demographic characteristics; it was an indicative that a comparison of these two groups was balanced.

There was no significant difference between the two groups in terms of averages of age. The averages of age were appropriate for the ages that psychiatric disorders were more seen. (Kaplan&Sadock, 2007). The ratio of male and female was 3/1 in the group. These data were close to previous studies (Pedersen et al., 2014, Stevenson et al., 2011).

In terms of marital status, the number of singles in both groups was greater, but there was no significant difference between the two groups. Although it is found that psychiatric disorders are lower than divorced and grass widow in married people in the studies on the relationship of psychiatric disorders with marital status, the number of married people in general psychiatric population is greater. (Kaplan&Sadock, 2007).

Considering the distribution of psychiatric disorders in terms of SCID I, it was observed that neurotic group is mostly depressive disorder, anxiety disorder and undifferentiated somatoform disorder. There was no undifferentiated somatoform disorder in male neurotic group. It is supported in the studies on the subject that the majority of patients with undifferentiated somatoform disorder were of female, and stressful life events would be a risk factor in the emergence of the disease (Kaplan&Sadock, 2007, Pribor et al., 1993).

The prevalence of personality disorders were found between 3.9% 22.3% by different studies (Kaplan&Sadock, 2007, Zimmerman et al., 2008, Dereboy et al., 2014, Coid et al., 2006) Cluster C personality disorders also known as neurotic cluster are the most common disorders (1 in 10 people)in the general population (Torgersen et al., 2001).

In terms of SCID-II, the neurotic group significantly was taking high diagnosis compared to the control group in terms of avoidant personality disorder. Subjects in the control group consisted of those not receive a diagnosis of personality disorder and therefore there was no one taking diagnosis.

Secondary anxiety (particularly social phobia), and depressive symptoms improvements to the avoidant personality disorder basic of neurotic patients group is an expected finding for the patient profiles of avoidant personality disorder (Kaplan&Sadock, 2007). Also it is known that neurotic patients express their unconscious conflicts through depressive anxious and somatic ways. (Kaplan&Sadock, 2007).

In terms of Beck Depression Scale, the average scores were 4.94 in the control group and 14.45 in the neurosis group. The neurotic group scores were significantly higher than the control group. Reason for the high level of neurotic group score was that almost all of them were probably in an active Axis I disorder and avoidant personality disorder were more frequent. There are also evidence that people with high neuroticism feel more lonely themselves. (Iacoviello et al, 2007). In general, depression combination with psychiatric disorders is a common frequent. (Tümkaya et al., 2005).

Cluster B personality disorders were associated with the severity of depression and Cluster C personality disorders with the chronicity of depression in a depression study and it was said that those having cluster C personality disorders were more anxious.(Levin&Stokes, 1986).

In terms of State-Trait Anxiety Inventory, the average of neurotic patients was significantly higher than the control group. It was an expected finding in terms of our present study. We indicated for SCID I in our study, the neurotic group showed mostly the significance for depressive disorders and anxiety disorders. (1 axis) anxiety disorders or anxiety semptoms are a finding frequently observed in psychiatric disorders, (Kessler et al., 2005) and it was reported in several studies that depression and anxiety disorders were most frequently observed diagnoses. (Zimmerman et al., 2008, Kessler et al., 2005).

In terms of Sheehan disability scale, the average of neurosis group was significantly higher than the control group. The lowest average in terms of family life and household responsibilities was in the control group. It was seen that the disabilities were in middle level in male neurotic group while there were mild disabilities in general neurotic group and female neurotic group in Sheehan disability. In our study, Beck depression scores had been significantly higher in the neurosis group, this may be a condition that affects the functionality. In a study conducted, it was observed that there was an important functional loss in depressed patients (Kongsakon et al, 2005). Also, neurotic organizing patients were more evident compared to the control group at any diagnoses point in SCID-I, the reduction of functionality in psychiatric disorders is a known state. (Kırkpınar&Oral, 2012).

Considered the Family Assessment Scale, There is a direct correlation between the increase in unhealthiness

with the rise of points in the family assessment scale. The control group was significantly than neurosis group in the items problem solving and problem solving among men between these scale groups. So especially problem solving ability of men and of the neurotic group was significantly lower than the control group. Considered avoidant personality disorder and anxiety and depressive features of the neurotic group, it is is understandable that the abilities to solve problems are low.

Considering the work done by FAD, the families where there are members with mental problems have been found unhealthy than controls. (Bulut, 1990). In this study problem solving and behavior control are unhealthy commonly seen in people with neurotic personality organization, problem-solving is indicative of insufficient, masked or transposed communication among the family members. Behavior control shows the inability to set standard and to provide the discipline to the behaviors of family members. Unhealthy function observed in these two areas can be considered support each other.

In terms of Minnesota Multiphasic Personality Inventory, any subscale did not exceed 70 points in both groups, when groups are compared to one another: The average score of neurotic patient group was significantly higher than the control group in terms of Hypochondriasis, depression, hysteria, and social introversion subscales. Hypochondria subscale indicates the somatic defense and the presence of somatic symptoms relation with psychological uneasy. In our study, somatoform disorders in neurotic patients have a high rate.

Being high of depression subscale was consistent with our study. Beck depression scores we mentioned earlier was significantly compared to the control group in the neurotic group. Obviously, the presence of social introverted personality characteristics was important for patients in these diagnostic groups. In the remark of MMPI, social introversion may point the presence of symptoms such as shyness, withdrawal of social relationships, self-humiliation, self-distrust, feelings of guilt, sensitivity to others' ideas, instability and pessimism. In our study, social introversion item of the MMPI results were extremely significant when compared to the control group with the neurotic group. In addition, in our study in line with this data, SCID-II avoidant personality disorder and SCID-I anxiety and depression features were significantly found in the neurotic people compared to the control group.

In our study, Hysteria subscale was significantly in the neurotic group compared to the control group. Hysteria subscale reflects the tendency to apply to physical symptoms due to escape from responsibility and problems, as known physical symptoms are common in neurotic patients. (Kaplan&Sadock, 2007).

As a result, it may be considered that avoidant personality structuring of neurotic individuals is more prominent and accordingly the secondary anxiety and depressive symptoms improve. It can be said that all of these processes impair disability of these individuals, domestic problem solving and behavior control abilities. Again, as a result of MMPI, the average scores of neurotic patient group in terms of hypochondriasis, depression, hysteria,

and social introversion subscales are significantly higher than the control group and it supports this process.

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