

Somatic Symptom Burden Across Schizophrenia, Obsessive–Compulsive Disorder, and Anxiety Disorders: An Illustrative Synthetic Study

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Abstract

Background: Physical complaints frequently accompany psychiatric disorders, complicating assessment and potentially obscuring treatable medical conditions. Comparing somatic burden across diagnostic groups can illustrate the value of integrated psychiatric, psychological, and addiction assessment. Objective: To demonstrate a transparent descriptive framework for examining somatic symptoms in schizophrenia, obsessive–compulsive disorder, and anxiety disorders without presenting invented observations as clinical evidence. Methods: An explicitly synthetic dataset represented 120 hypothetical adults, equally allocated to three diagnostic groups. Constructed variables included diagnostic category, Patient Health Questionnaire–15 symptom band, and a binary indicator of recent nonmedical substance use. Moderate-to-high somatic burden was defined as a questionnaire score of at least 10. Frequencies and percentages were calculated directly from assigned counts; no recruitment, patient records, or inferential testing were involved. Results: Moderate-to-high somatic burden was assigned to 18 of 40 schizophrenia profiles, 24 of 40 obsessive–compulsive profiles, and 28 of 40 anxiety profiles. Corresponding proportions were 45%, 60%, and 70%. Recent nonmedical substance use was assigned to 12, 8, and 10 profiles, respectively. Overall, 70 profiles had elevated somatic burden and 30 had substance-use indicators. Conclusion: The constructed pattern illustrates how diagnostic labels, bodily symptoms, and substance use can be summarized within one assessment framework. These values demonstrate reporting procedures rather than prevalence, causation, or treatment effects. Prospective clinical research would require validated measurements, medical evaluation, informed consent, and adjustment for relevant confounders.

Keywords: schizophrenia, obsessive–compulsive disorder, anxiety disorders, somatic symptoms, substance use, integrated assessment, synthetic data

1. Introduction

Psychiatric disorders frequently present with overlapping cognitive, emotional, behavioral, and physical symptoms that do not fit neatly within a single diagnostic category. Schizophrenia, obsessive–compulsive disorder, anxiety-related conditions historically described as neuroses, and

disorders characterized by prominent somatic symptoms illustrate this clinical complexity. Although these conditions differ in their defining features and treatment requirements, they may share substantial psychological distress, impaired daily functioning, and difficulties engaging with care. Substance use can further complicate presentation and management. Understanding these intersecting dimensions is important for psychiatric services seeking to provide assessment and coordinated treatment rather than relying exclusively on categorical diagnoses.

Schizophrenia is a heterogeneous psychiatric disorder involving disturbances in perception, thought, motivation, and cognition. Its clinical burden extends beyond hallucinations and delusions to include negative symptoms, cognitive difficulties, affective symptoms, and limitations in social or occupational functioning. Anxiety and obsessive-compulsive symptoms may also occur in people with schizophrenia, but their interpretation requires careful assessment. Repetitive thoughts can reflect obsessions, delusional preoccupations, depressive rumination, or responses to psychotic experiences. These phenomena are not interchangeable, and distinguishing them depends on their content, associated distress, degree of conviction, resistance, and relationship to other symptoms. Failure to recognize such differences may obscure clinically relevant comorbidity and complicate treatment planning.

Obsessive-compulsive disorder is characterized by intrusive, unwanted thoughts, urges, or images and by repetitive behaviors or mental acts performed in response to distress or perceived rules. The older expression “obsessional neurosis” broadly corresponds to aspects of this presentation, although contemporary diagnostic terminology offers greater precision. Similarly, “neurosis” is not a single modern diagnostic entity and may encompass several anxiety-related or stress-related conditions in historical and local clinical usage. For research purposes, these terms therefore require explicit operational definitions. Dimensional assessment of anxiety and obsessive-compulsive symptoms can complement diagnostic classification while preserving distinctions between disorders with different clinical trajectories.

Physical symptoms represent another important interface between psychiatry and medical psychology. Patients may report pain, fatigue, gastrointestinal discomfort, palpitations, or other bodily complaints alongside psychological distress. The term “psychosomatic” is used variably and should not imply that symptoms are imagined or that an underlying medical condition has been excluded. Psychological processes, physiological responses to stress, health behaviors, and established physical disease may interact in shaping symptom experience and disability. Somatic symptom burden can consequently be clinically meaningful across diagnostic groups, irrespective of whether criteria for a specific somatic symptom disorder are met. Assessment must acknowledge both mental and physical health needs.

Substance use adds a further dimension relevant to psychiatry and addiction medicine. Alcohol, cannabis, sedatives, stimulants, and other substances may influence anxiety, sleep, cognition, psychotic experiences, and perceived bodily discomfort. Relationships between substance use and psychiatric symptoms are often bidirectional and may also reflect shared social or clinical vulnerabilities. Some patients describe using substances to manage distress, whereas intoxication, withdrawal, or sustained use may aggravate symptoms and interfere with treatment. Nevertheless, substance exposure should not automatically be treated as the explanation for psychiatric difficulties. Its timing, pattern, severity, and relationship to symptom onset require separate evaluation.

Despite recognition of these overlaps, clinical assessment often remains organized around the principal diagnosis. This approach may leave accompanying obsessive-compulsive symptoms, anxiety, somatic complaints, or problematic substance use insufficiently characterized. Comparing these dimensions within a common assessment framework could identify needs that are less apparent from diagnostic labels alone. Interpretation must nevertheless account for factors such as age, illness duration, medication exposure, physical comorbidity, and social circumstances. In particular, associations observed in a cross-sectional clinical sample cannot establish whether psychological distress precedes somatic symptoms, results from them, or reflects reciprocal influences.

Against this background, the present observational study was designed to examine obsessive-compulsive symptoms, anxiety, somatic symptom burden, substance use, and functional

impairment among adults receiving psychiatric care for schizophrenia or nonpsychotic anxiety-related and somatic symptom presentations. The primary objective was to characterize differences and overlap across diagnostic groups using standardized clinical assessment. A secondary objective was to examine whether symptom dimensions and substance use were associated with functional impairment after accounting for relevant demographic and clinical characteristics. This approach was intended to support more individualized assessment while avoiding causal interpretations beyond the study design.

2. Materials and Methods

A multicenter, cross-sectional observational study will be conducted in adult outpatient psychiatry, medical psychology, and addiction services at three participating hospitals. The study will examine associations between obsessive-compulsive symptoms, psychological distress, somatic symptom burden, and substance use across schizophrenia, obsessive-compulsive disorder, anxiety disorders, and somatic symptom disorder. These categories will be treated as distinct diagnostic groups rather than interchangeable manifestations of “neurosis.” Recruitment will occur over 12 months. The protocol will require institutional ethics committee approval before enrollment, and all participants will provide written informed consent. Reporting will follow established guidance for observational studies.

Eligible participants will be aged 18–65 years, able to complete assessments in Uzbek or Russian, and receiving outpatient care for one of the four diagnostic categories. Schizophrenia will require an established diagnosis and sufficient clinical stability to participate, defined as no psychiatric hospitalization or major antipsychotic treatment change during the preceding four weeks. The anxiety group will include generalized anxiety disorder, panic disorder, and social anxiety disorder. Somatic symptom disorder will require clinically significant symptom-related thoughts, feelings, or behaviors; the absence of a medical explanation will not be required. Obsessive-compulsive disorder will require intrusive obsessions, compulsions, or both that cause distress or functional impairment.

Exclusion criteria will include delirium, a known major neurocognitive disorder, an acute medical condition preventing assessment, current intoxication or clinically significant withdrawal, and immediate suicide risk requiring emergency intervention. Intellectual or communication difficulties will justify exclusion only when they prevent valid consent or assessment despite reasonable assistance. Stable chronic medical conditions and nonacute substance use disorders will not be exclusion criteria. Participants unable to consent during acute deterioration may be reconsidered after stabilization, without delaying necessary treatment.

Consecutive potentially eligible patients will be approached during routine clinic attendance. Screening logs will document eligibility, participation, and broad reasons for nonparticipation without retaining identifiable information about individuals who decline. The target sample will be 360 participants, approximately 90 per diagnostic group. This target allows for approximately 15% incomplete primary outcome data, leaving around 306 analyzable observations. Under a two-sided significance level of 0.05, this number provides approximately 80% power to detect an unadjusted correlation of 0.16. This calculation provides a feasibility-based benchmark; it does not guarantee equivalent power for adjusted associations, subgroup comparisons, or interactions.

Diagnoses will be established by trained psychiatrists using the Structured Clinical Interview for DSM-5 Disorders, supported by clinical records and patient interviews. The principal diagnosis will reflect the condition chiefly responsible for the current treatment episode. Additional diagnoses will be recorded rather than excluded, allowing clinically representative comorbidity. When schizophrenia and obsessive-compulsive disorder coexist, principal-group assignment will follow the same rule. Clinicians will distinguish obsessions from delusions by assessing intrusiveness, resistance, associated compulsions, and the relationship to psychotic experiences; limited insight alone will not rule out obsessive-compulsive disorder. Uncertain assignments will undergo consensus review by two psychiatrists.

The primary outcome will be somatic symptom burden measured using the Patient Health Questionnaire-15. Scores will be interpreted as symptom burden rather than evidence of psychological causation. The primary explanatory measure will be the Obsessive-Compulsive

Inventory-Revised total score. Depressive and anxiety symptoms will be assessed using the Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7 scale. Functional impairment will be measured with the 12-item World Health Organization Disability Assessment Schedule. Participants with schizophrenia will additionally receive the Positive and Negative Syndrome Scale, while those with obsessive-compulsive disorder will receive the Yale-Brown Obsessive Compulsive Scale to characterize disorder-specific severity.

Substance involvement will be assessed with the Alcohol, Smoking and Substance Involvement Screening Test. Substance classes, recent frequency, prescribed psychoactive medication use, and clinician-diagnosed substance use disorders will be documented separately. Tobacco exposure will not be combined with other substances into an unsupported composite score. Medical records will provide illness duration, psychiatric admissions, current medications, and documented chronic medical conditions. Demographic variables will include age, sex, education, employment, and living arrangements. Antipsychotic exposure will be summarized using a prespecified dose-equivalence method where applicable; antidepressant and sedative exposure will be recorded by class and daily dose.

Assessments will occur during one visit, with breaks permitted, and will take approximately 75–100 minutes. Existing validated language versions will be preferred. Where unavailable, translation, independent back-translation, expert review, and cognitive interviews with 10 nonstudy patients per language will precede recruitment. Translated instruments will not be assumed equivalent solely on this basis. Assessors will complete standardized training, and a consented 10% subsample will undergo independent diagnostic and clinician-rating assessments. Agreement will be summarized using kappa statistics and intraclass correlation coefficients. Questionnaire data will be entered into a restricted-access database with range checks and a deidentified audit trail.

The primary analysis will estimate the association between obsessive-compulsive symptoms and somatic symptom burden using multivariable linear regression with heteroskedasticity-robust standard errors. Prespecified covariates will include diagnostic group, site, age, sex, illness duration, depressive symptoms, anxiety symptoms, chronic medical condition count, and non-tobacco substance involvement. Estimates will be reported with 95% confidence intervals. Diagnostic-group interactions will be exploratory. Model checks will address nonlinearity, influential observations, and collinearity. Missing covariates will be multiply imputed when a missing-at-random assumption is plausible, with complete-case analyses for comparison. Sensitivity analyses will exclude participants with comorbid obsessive-compulsive disorder from other groups and assess language-related differences. Secondary comparisons will use false-discovery-rate adjustment. Because measurements are cross-sectional, associations will not be interpreted as causal or temporally ordered.

3. Results

In this hypothetical observational dataset, 268 adults attending outpatient psychiatry, medical psychology, and addiction services were screened, and 240 were included in the baseline analysis. Exclusions comprised insufficient diagnostic information ($n = 12$), acute intoxication or withdrawal preventing assessment ($n = 9$), and inability to complete the assessment procedures ($n = 7$). Participants were assigned to four mutually exclusive primary diagnostic groups: schizophrenia, obsessive-compulsive disorder, anxiety disorders, and somatic symptom disorder, with 60 participants per group. Assignment reflected the principal condition responsible for the index consultation; additional psychiatric diagnoses were recorded separately.

The median age was 36 years (interquartile range [IQR], 28–45), and 132 participants (55.0%) were women. Women represented 40.0% of the schizophrenia group, 56.7% of the obsessive-compulsive disorder group, and 61.7% of both remaining groups. Overall, 106 participants (44.2%) were employed, 78 (32.5%) were unemployed, and 56 (23.3%) were students, retired, or otherwise outside the workforce. Employment was least frequent among participants with schizophrenia (26.7%) and ranged from 45.0% to 55.0% in the other groups.

Baseline symptom burden, functioning, and substance use findings are summarized in Table 1. Scores are presented descriptively because the diagnostic groups differed in illness duration and treatment exposure. Depressive symptoms were common across all four groups, whereas anxiety scores were

numerically highest among participants with obsessive-compulsive disorder and anxiety disorders.

Table 1. Baseline characteristics by primary diagnostic group in the hypothetical cohort

Characteristic	Schizophrenia (n = 60)	Obsessive-compulsive disorder (n = 60)	Anxiety disorders (n = 60)	Somatic symptom disorder (n = 60)
Age, years, median (IQR)	38 (29–47)	32 (25–41)	35 (28–43)	40 (31–49)
Illness duration, years, median (IQR)	8 (4–14)	5 (2–9)	4 (2–8)	5 (2–10)
PHQ-9 score, median (IQR)	11 (7–16)	12 (8–16)	11 (7–15)	9 (6–14)
GAD-7 score, median (IQR)	8 (4–12)	13 (9–17)	14 (10–18)	10 (6–14)
WHODAS 2.0 simple sum, median (IQR)	22 (16–29)	16 (11–22)	14 (9–20)	17 (12–23)
Current substance use disorder, n (%)	18 (30.0)	7 (11.7)	10 (16.7)	8 (13.3)

The Patient Health Questionnaire depression scale (PHQ-9), Generalized Anxiety Disorder scale (GAD-7), and 12-item World Health Organization Disability Assessment Schedule (WHODAS 2.0) were completed by all included participants. Higher scores indicated greater symptom severity or disability; WHODAS simple sums ranged from 0 to 48. PHQ-9 scores of at least 10 occurred in 129 participants (53.8%): 35 with schizophrenia, 33 with obsessive-compulsive disorder, 32 with anxiety disorders, and 29 with somatic symptom disorder. This threshold represented elevated depressive symptoms rather than an independently established depressive diagnosis.

Recurrent unwanted thoughts were reported by 112 participants (46.7%), including 48 with obsessive-compulsive disorder, 19 with schizophrenia, 25 with anxiety disorders, and 20 with somatic symptom disorder. These reports were not treated as diagnostically equivalent: clinical assessment distinguished intrusive, resisted thoughts from delusional preoccupations and generalized worry. Consequently, their pooled frequency described a broad presenting complaint rather than the prevalence of obsessions.

A current substance use disorder was identified in 43 participants (17.9%). Alcohol-related disorders accounted for 25 cases, cannabis-related disorders for 11, and other substance-related disorders for seven, classified by the principal substance involved. Their numerical concentration in the schizophrenia group did not establish a diagnostic association independently of demographic or clinical differences.

Ongoing psychotropic medication use was recorded in 185 participants (77.1%), including 56 with schizophrenia, 47 with obsessive-compulsive disorder, 43 with anxiety disorders, and 39 with somatic symptom disorder. Psychological treatment during the preceding three months was reported by 84 participants (35.0%). These baseline observations do not establish treatment response or temporal relationships between symptoms, disability, and substance use.

The following results describe an illustrative, simulated cohort rather than observed patient data. Among 240 adults distributed equally across schizophrenia, obsessive-compulsive disorder, other anxiety-related disorders, and psychosomatic presentations, 216 completed the 12-week assessment. Follow-up completion was identical across diagnostic groups, with 54 participants retained in each group. Participants who did not complete follow-up had slightly higher baseline distress scores, although the uncertainty around this difference precluded a clear conclusion about selective attrition.

Across participants with complete assessments, psychological distress decreased during follow-up. Mean scores on the 21-item Depression Anxiety Stress Scales, calculated using the unmultiplied total score, declined from 32.8 (standard deviation, 10.6) to 25.9 (standard deviation, 11.2). The mean within-participant reduction was 6.9 points (95% confidence interval, 5.2–8.6). Because participants

received heterogeneous routine care and no untreated comparison group was included, this change could not be attributed to a specific therapeutic component. Adjustment for age, sex, diagnostic group, and baseline substance use did not materially alter the direction of the association between assessment time and distress.

Diagnostic groups showed different patterns of symptom change. Among participants with schizophrenia, improvement was more apparent for positive symptoms than for negative symptoms, while social withdrawal frequently persisted. Participants with obsessive-compulsive disorder showed reductions in both intrusive thoughts and compulsive behaviors, but residual avoidance remained common. In the anxiety-related group, autonomic arousal and sleep complaints decreased alongside subjective anxiety. Among participants with psychosomatic presentations, distress improved more consistently than physical symptom burden. These within-group patterns were descriptive; the study did not establish that one diagnostic group benefited more than another.

Functioning improved modestly across the cohort. Mean scores on the 12-item World Health Organization Disability Assessment Schedule, using simple scoring from 0 to 48, decreased from 21.4 to 18.3 among completers. Improvement in functioning was associated with reduction in distress after adjustment for diagnostic group and baseline disability. However, several participants reported lower distress without corresponding improvement in employment, household responsibilities, or interpersonal participation. Functional recovery therefore appeared incomplete over the relatively short observation period.

Baseline screening identified clinically relevant alcohol or other substance use in 60 participants. Of these, 51 completed follow-up, compared with 165 of the 180 participants without a positive substance-use screen. Participants screening positive had higher baseline distress and disability scores. In an adjusted exploratory model, baseline substance use was associated with a 2.4-point smaller reduction in distress (95% confidence interval, 0.3–4.5). This association should not be interpreted as a causal effect because substance-use severity, treatment exposure, and social disadvantage were not fully characterized.

Sleep disturbance remained a prominent residual complaint. At follow-up, 94 of 216 participants reported clinically relevant sleep difficulties, including individuals whose principal psychiatric symptoms had improved. Persistent sleep complaints co-occurred with greater disability and more frequent somatic complaints, but their temporal relationship could not be determined from two assessment points.

Sensitivity analyses using multiple imputation for missing follow-up scores produced estimates of overall distress reduction similar to those from complete cases. Under a more conservative assumption that participants lost to follow-up experienced no improvement, the estimated mean reduction was attenuated but remained positive. Exploratory subgroup estimates were less precise, particularly for substance use within individual diagnostic categories. No consistent diagnosis-by-substance-use interaction was identified. Overall, the simulated findings indicated partial symptomatic improvement accompanied by persistent functional, sleep-related, and somatic difficulties, with substantial variation between individuals that was not explained by diagnostic category alone.

4. Discussion

The relationships among psychotic symptoms, obsessive-compulsive phenomena, anxiety, somatic complaints, and substance use require interpretation across both diagnostic and functional dimensions. In a psychiatric clinical population, these domains may overlap without representing a single underlying disorder. Their coexistence can complicate assessment, particularly when the presenting complaint emphasizes bodily discomfort rather than psychological distress. The principal clinical implication is therefore not to replace established diagnoses with a broad category of distress, but to consider whether diagnosis-specific assessment adequately captures the symptoms, behaviors, and contextual pressures relevant to each patient's functioning.

An important distinction concerns intrusive thoughts in obsessive-compulsive disorder and abnormal beliefs in schizophrenia-spectrum disorders. Obsessions are typically recurrent, unwanted experiences

associated with distress and attempts at suppression or neutralization, whereas delusions involve beliefs held with substantial conviction despite contradictory evidence. Nevertheless, insight varies in both conditions, and the distinction may become less clear when obsessive symptoms are severe or psychotic symptoms are partially treated. Consequently, symptom interpretation should incorporate the person's relationship to the thought, degree of conviction, resistance, associated rituals, and longitudinal history. Reliance on unusual thought content alone could produce diagnostic misclassification and obscure clinically meaningful comorbidity.

The term neurosis also requires careful handling. Although it remains familiar in some clinical traditions, it does not correspond to a single contemporary diagnostic entity. Anxiety disorders, obsessive-compulsive disorder, trauma-related conditions, and some somatic symptom presentations differ in their defining features and recommended treatment approaches. Grouping them together may offer a broad description of nonpsychotic distress, but it can conceal differences in severity, chronicity, and functional impairment. Any comparison involving a broadly defined neurotic group should therefore be interpreted as exploratory unless the constituent diagnoses and assessment procedures are clearly specified.

Somatic complaints warrant similarly nuanced interpretation. Psychological distress can influence bodily perception, autonomic arousal, sleep, pain processing, and healthcare-seeking behavior, but these pathways do not establish that physical symptoms lack a medical basis. Psychiatric and medical disorders frequently coexist, and either may worsen the burden of the other. A psychosomatic formulation is most useful when it describes interacting biological, psychological, and social contributors rather than assigning symptoms exclusively to emotional causes. Clinically, this supports proportionate medical evaluation alongside assessment of health anxiety, symptom-related behaviors, disability, and the patient's understanding of illness.

Substance use adds another layer of complexity because intoxication, withdrawal, and sustained exposure may alter anxiety, sleep, cognition, and psychotic experiences. Conversely, individuals may use alcohol or other substances in an attempt to manage distress or medication-related discomfort. These explanations are not mutually exclusive, and observational relationships cannot establish their temporal sequence. Assessment should distinguish substance exposure from a diagnosed substance use disorder and document the timing of symptoms relative to use. Without such information, apparent differences between diagnostic groups may partly reflect unmeasured exposure, withdrawal states, or treatment adherence rather than the primary psychiatric condition.

Functional impairment provides a clinically valuable point of comparison across these presentations. Symptom counts alone may underestimate burden when avoidance, social withdrawal, compulsive behavior, or repeated medical consultations substantially disrupt daily life. Equally, similar symptom scores can coexist with different levels of occupational participation and family support. Interpretation should therefore consider functioning as a related but distinct outcome, rather than assume that greater symptom severity necessarily produces proportionately greater disability. This distinction is especially relevant when identifying priorities for individualized care.

Potential shared mechanisms include persistent threat appraisal, difficulties regulating emotion, disrupted sleep, and reduced social participation. However, these remain explanatory hypotheses unless directly measured and tested. Medication effects, illness duration, socioeconomic adversity, and coexisting medical conditions could also account for observed relationships. In particular, associations between treatment exposure and symptom burden may reflect confounding by indication, because more severely affected patients often receive more intensive treatment. Accordingly, the clinical value of a transdiagnostic interpretation lies in prompting comprehensive assessment, not in demonstrating a common cause or establishing the superiority of a particular intervention. Diagnostic specificity and attention to shared difficulties should be viewed as complementary approaches that can guide subsequent longitudinal investigation and more coordinated psychiatric, psychological, medical, and substance-use care.

The clinical implications of these findings should be considered within a transdiagnostic framework rather than interpreted as evidence that schizophrenia, obsessive-compulsive disorder, anxiety-related conditions, and psychosomatic presentations represent a single disease process.

These conditions may share distress, sleep disruption, impaired functioning, and difficulties regulating attention or emotion, while differing substantially in phenomenology, prognosis, and treatment requirements. Their clinical overlap therefore supports comprehensive assessment, not diagnostic substitution. In particular, repetitive thoughts require careful characterization because intrusive, unwanted obsessions differ from fixed delusional beliefs, although insight may vary and mixed presentations can complicate classification.

For psychiatric and medical psychology services, this framework favors assessment of both symptom severity and everyday functioning. A patient whose symptom score improves may continue to experience substantial occupational, interpersonal, or self-care difficulties. Conversely, functional recovery may occur despite persistent symptoms. Treatment planning should therefore incorporate personally meaningful goals, medication tolerability, cognitive functioning, and social circumstances. Where obsessive-compulsive symptoms are present, psychological interventions should be matched to their specific maintaining mechanisms rather than applied solely on the basis of a broad anxiety or historical “neurosis” label. In schizophrenia, psychological and psychosocial care should complement, rather than replace, indicated pharmacological management.

Somatic complaints warrant an equally balanced approach. Associations between psychological distress and bodily symptoms do not establish that symptoms are exclusively psychological, nor do they exclude concurrent medical disease. Premature attribution to psychosomatic mechanisms may delay appropriate investigation and undermine trust. A coordinated pathway involving primary care, relevant medical specialties, and mental health professionals may help reduce fragmented assessment while preserving diagnostic vigilance. Explanations should acknowledge that physiological, behavioral, and contextual factors can interact without implying that symptoms are imagined. This approach is especially important when repeated consultations or investigations have not produced a satisfactory explanation.

The relevance of narcology lies in the potential contribution of alcohol, sedatives, stimulants, and other psychoactive substances to symptom expression and treatment response. Intoxication, withdrawal, and longer-term substance exposure may resemble or aggravate anxiety, psychosis, sleep disturbance, and somatic discomfort. Nevertheless, co-occurrence alone cannot determine whether substance use precedes psychiatric symptoms, follows attempts at self-medication, or reflects shared vulnerability. Routine, nonjudgmental screening is therefore justified, together with attention to prescribed medications and interactions. When substance-related problems are identified, coordinated treatment is preferable to interpreting persistent symptoms as evidence of treatment resistance before these contributing factors have been assessed.

Several methodological considerations limit interpretation. Observational associations cannot establish temporal sequence or causality, and statistical adjustment cannot eliminate residual confounding. Clinical samples may overrepresent individuals with greater severity, better service access, or willingness to disclose symptoms, limiting applicability to community populations. Diagnostic heterogeneity also complicates comparison: broad categories such as neurosis or psychosomatic illness may encompass disorders with distinct mechanisms. Self-reported symptoms can be influenced by current mood, recall, stigma, and culturally shaped descriptions of distress. Clinician assessment provides complementary information but is also vulnerable to variability in interviewing and diagnostic judgment. Medication exposure, illness duration, physical comorbidity, and substance use should consequently remain central considerations when interpreting between-group differences.

Future research should prioritize longitudinal designs that establish whether changes in psychological distress, substance exposure, and somatic burden precede or follow changes in psychiatric functioning. Repeated assessments could clarify within-person trajectories more effectively than single measurements. Recruitment across psychiatric, addiction, and general medical settings would improve representation and help distinguish service-specific patterns from broader clinical relationships. Standardized diagnostic interviews, culturally appropriate instruments, and clearly defined functional outcomes would strengthen comparability. Where feasible, patient-reported outcomes should be combined with clinical and behavioral measures, while avoiding assumptions that biological markers necessarily provide greater diagnostic specificity.

Overall, the most defensible clinical message is the need for differentiated but integrated care. Shared distress and impairment justify collaboration across psychiatry, medical psychology, addiction medicine, and general healthcare, whereas disorder-specific features must continue to guide treatment selection. The present interpretation should be regarded as hypothesis-generating rather than a basis for changing diagnostic boundaries or prescribing practice. Its practical value lies in encouraging careful differential diagnosis, attention to potentially modifiable contributors, and evaluation of recovery beyond symptom reduction alone.

5. Conclusion

The principal conclusion is that schizophrenia, obsessive-compulsive symptoms, neurotic presentations, and psychosomatic complaints require differentiated clinical assessment within an integrated psychiatric and medical framework. Although these presentations may share distress, sleep disturbance, impaired functioning, and difficulties with emotional regulation, their overlap does not establish a common disease process or justify interchangeable treatment. Their clinical significance depends on symptom structure, duration, severity, insight, accompanying medical conditions, and the influence of substance use. Diagnostic precision therefore remains essential even when care is organized around shared patient needs.

A central implication is the importance of distinguishing intrusive, unwanted thoughts from delusional beliefs and other psychotic experiences. Assessment should examine the patient's relationship to the thought, associated compulsive behavior, degree of conviction, and capacity to consider alternative explanations. Insight can vary, so no single feature should determine classification. Likewise, the broad term "neurosis" is most useful when translated into specific, clinically assessable anxiety, obsessive-compulsive, stress-related, or somatic symptom presentations rather than treated as a uniform diagnostic entity.

For patients presenting with bodily symptoms, psychological assessment should complement rather than replace appropriate medical evaluation. Somatic distress may coexist with demonstrable physical disease, and the identification of anxiety or depression does not establish that a complaint is exclusively psychological. A balanced approach should validate suffering, investigate relevant warning signs, and avoid both unnecessary repeated testing and premature psychiatric attribution. Coordination between mental health professionals and other clinicians may support clearer explanations and more consistent management, although improvements in outcomes require direct evaluation.

Substance use deserves systematic attention across these diagnostic groups because intoxication, withdrawal, and persistent use can complicate symptom interpretation, adherence, and risk assessment. Management should address substance-related problems alongside psychiatric symptoms, with treatment selected according to the individual clinical formulation. Evidence-based psychotherapy, appropriate pharmacotherapy, psychoeducation, and rehabilitation should be considered complementary options rather than universal components of a fixed treatment package. Patient preferences, cognitive capacity, family circumstances, and access to services should inform implementation.

The interpretation of research in this area must remain proportionate to its design. Symptom associations alone cannot establish causality, predict long-term course, or demonstrate treatment effectiveness. Potential diagnostic overlap, reporting differences, unmeasured medical contributors, and variation in substance exposure should temper conclusions. Longitudinal studies using standardized assessments and clearly defined diagnostic groups are needed to clarify temporal relationships and identify clinically meaningful predictors of recovery.

Ultimately, the most defensible clinical direction is individualized, coordinated care that combines diagnostic rigor with attention to functioning and lived experience. Future evaluation should prioritize sustained symptom improvement, quality of life, social participation, treatment tolerability, and patient-defined recovery. Such an approach offers a practical foundation for improving psychiatric, psychological, and addiction care without overstating the certainty of the available evidence.

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