Journal of Psychological and
Educational Research
JPER - 2015, 23 (2), November, 90-110

INTERVENTION FOR CHRONIC DYSTHIMIA: A CASE STUDY ON DIAGNOSTIC UNCERTAINTY

Tudor-Ştefan Rotaru [*]
University of Medicine and Pharmacy "Gr. T. Popa" of Iaşi, Romania

Ana Roxana Hîngănescu
Alexandru Ioan Cuza University, Romania

Teodora Alexa
University of Medicine and Pharmacy "Gr. T. Popa" of Iași, Romania

Abstract
This article presents a psychotherapeutic intervention for a young man with a particular psychological structure. The client complains about depressed mood and derealization. Conceptualizations for this case have various perspectives: cognitive-behavioral, Eriksonian and humanistic. The examination reveals psychotic elements, but the urgency for medication is contradicted by the psychiatrist. The therapeutic intervention used small steps and found suitable ways for evaluation and treatment. Therapy seemed the best option, urging the client to develop a more positive attitude and way of thinking. More than two years since his therapy's end, patient feels he made the right choice by visiting the therapist. He seems thoroughly adapted at multiple levels of his professional and personal life.

Keywords: clinical case study; depression; dysthymia; schizotypal

Introduction

The purpose of this case study is to describe the therapeutic interventions along ten psychotherapy sessions that brought about significant

Correspondence concerning this paper should be addressed to:

[*] Ph.D., University of Medicine and Pharmacy "Gr. T. Popa" of Iași, Centre for Ethics and Health Policy. Address: Universităţii st., No. 16, Iaşi, Romania, Europe. E-mail: *tudor.rotaru@umfiasi.ro*

changes in the patient's life, despite relative uncertainty concerning a nosology label. This case is chosen for of the analysis of possible causes for derealization, depression and suspected psychotic features. These make the case a challenge from the point of view of possible causes and interventions. We want to draw attention to this clinical case to make better sense of how therapy works, how the joint efforts of a psychiatrist and psychotherapist should be understood and what difficulties can appear. Maybe the most important feature of this case is to understand how a depressive mood can manifest and how it can be treated.

Main complains

Daniel is a 21 year old technical student and visits the therapists for the first time in September 2012. At first glance he shows jumbled speech, hard to follow, in which introspection and elements of doubt are scattered in slow, slightly intermittent speaking with many syncopes. He seems uncomfortable sitting on the couch during the first session. He says *"I have the need to make a sense of some things I don't understand; I want an answer.* "Daniel complains about a big fluctuation of his mood: *"swings between good and bad"*. In the good moments he doesn't have an expansive disposition (maniacal), but, almost all the depressed moments start with an episode of derealization ("*something is wrong with all things around me; it seems I am an actor in a scene"*) and déjà-vu sensations, followed by feelings of despair. When negative feelings are at their maximum, Daniel feels he is being watched. He carefully looks out the window, to check if someone is spying on him. The therapist immediately suspected a psychotic component in Daniel's described experiences. Daniel also complained about frequent headaches. He describes himself as *"a freak"*. Life for Daniel is *"a strange balance between perception and reality; it goes too fast and it scares me; is like I'm not living my life; I can't find any life."* He has an open attitude but is somehow suspicious. He repeatedly asks for assurances concerning confidentiality of discussions and for a non-judgmental attitude of the therapist. He speaks openly, but refuses to have the sessions recoreded. Concerning his sleep, nights are described as peaceful without issues.

Personal and social history of the patient

Daniel has an early medical history. At birth, he was diagnosed with a malapsortion syndrome. At just two months old he had his first surgery for bowel problems. Afterwards he continued with other medical interventions that kept him in hospital for a long time. In the third grade, Daniel was involved in a car accident and was subsequently hospitalized for another period of time. Another critical phase for him happened during middle school and high school. Facing many difficulties from students and teachers, adapting to the social environment was his main concern. Colleagues looked down at him, considering him weird. They always bothered him with harassing words. Daniel didn't receive any support from his teachers. Moreover, they strengthened this debilitating label by putting him down in front of his peers: *"Let him be…he is a weirdo!"*

Daniel is the second child of a police superior officer and of a store manager. His father always preferred for Daniel to handle all his problems by himself, including the abusive experiences at school. He rarely intervened and when he did it was without success. Daniel describes his mother as an intrusive person. She pries into all of his life's aspects*: "She intrudes in my privacy"*. For instance, although the therapist was found by Daniel himself, it's the mother who made the first call for an appointment. Indeed, different moments of the therapist's interaction with Daniel seemed suspicious on that regard. Daniel didn't have a personal mobile phone. When called on any of the three different mobile numbers Daniel had listed, his mother answered. We showed in previous papers how family's pathological borders play a role in the maintenance of individual psychopathology (Rotaru & Petrov, 2014).

In his history, Daniel had three meetings with school psychologists at his parent's request. Daniel describes those meetings as being *"insipid"*. During the second session, on 5th October 2012, he brought his journal and, without allowing the therapist to read directly from it, Daniel read out loud some passages. Indeed, all of his personal history seems marked with indissoluble dilemmas and melancholy moments: *"The sky seems desolate, desecrated, abandoned…"; "What does it mean to be intelligent?"; "I feel I am not my own driver"; "Time is a friend and a thief…"; "Days become just hours…".*

After a few psychotherapy sessions, a philosophical dilemma was revealed*: "How do we know that our experience is real?"* This philosophical indissoluble dilemma had grinded Daniel for a long time, until a moment in therapy, when Daniel learned to dissociate things he could understand from things that were inaccessible for us as humans.

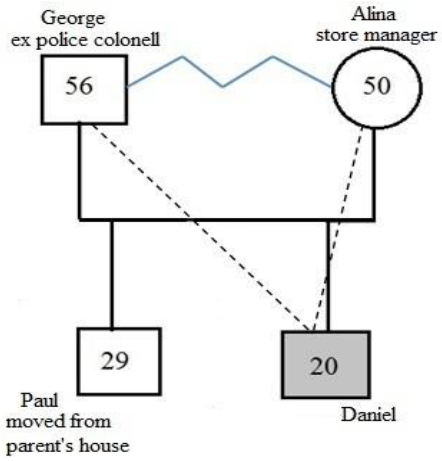

Figure 1. Daniel's family genogram

Elements of clinical evaluation

Daniel had at birth a malapsortion syndrome and suffered his first medical surgery at two months old. After this episode, he had several medical interventions and stayed a long time in hospital. Also, in the third grade, he was involved in a car accident and was again hospitalized. The psychiatrist Daniel visited at the therapist's recommendation mentioned the possibility that Daniel might have been affected by all these traumatic experiences.

From the point of view of a possible DSM-IV-TR diagnosis (American Psychiatric Association, 2000), the following provisional conclusions might be drawn. As shown below, a lot of diagnostic uncertainty is present, and this gap is confirmed by the psychiatrist as well.

1. Axis 1 *(clinical disorders)*: 296.24 - Major depressive episode or 300.4 dystimia disorder (unconfirmed) with depressed mood, low self-esteem, guilt.
2. Axis 2 *(personality disorders)*: 301.22 - There is a certain hypothesis for a schizotypal structure (which goes unconfirmed). Also, the patient has some psychotic elements (a feeling that he is spied upon) and derealization symptoms (déjà-vu, altered perception of environment).
3. Axis 3 *(general medical conditions)*: no significant elements.
4. Axis 4 *(psychosocial and environmental factors contributing to the disorder)*: V61.20 - problems with primary group support (family conflicts and a distant relationship) and V62.3- educational problems (problems with colleagues and teachers in high school).
5. Axis 5 *(Global Assessment of Functioning)*: GAF=60; Moderate symptoms (depressive mood present for seven or eight years, psychotic elements, derealization) and moderate difficulties in social functioning (two or three friends with no significant emotional bond, he prefers solitary activities instead).

Case conceptualization

The first attempt was to conceptualize the case using the medical-psychiatric model. After three therapy sessions, the therapist hardly convinced Daniel to visit a psychiatrist. Daniel visited the psychiatrist without his parents' knowledge, using the therapist as an accomplice. The parents not knowing of this visit was the condition Daniel set for visiting the psychiatrist. The visit to the psychiatrist's office happened during the time meant for a therapy session. The client forbade the therapist to reveal to his parents' some aspects of his treatment and absolutely refused his parents' presence in the therapy sessions. The psychiatrist sent Daniel back without pharmacological treatment. The medical doctor agreed that it was right to suspect a psychotic component, that Daniel was the at the right age and had a precedent for developing an active phase of schizophrenia. Surprisingly, the psychiatrist considered it worth to continue therapy without medication and if in a few sessions no significant results appeared, to resort to medication. The therapist was surprised the case evolved in an unexpectedly good way, and no medication was ever needed.

The therapist also conceptualized the case in a behavioral manner. He explained to Daniel that we behave depending on how we feel, but we also feel depending on the way we behave. This means that Daniel would have to plan some activities that often included interactions with people and less staying at home.

Another conceptualization was the cognitive one: Daniel assumes dilemmas that, historically, have no solutions. He doesn't need to take on the responsibility of understanding all things in the Universe. Some of them are a natural mystery. Also, this cognitive intervention allowed him to differentiate his own thoughts from reality.

Another conceptualization is the humanistic one. The therapist struggled to create a positive therapeutic relationship with the patient and to help him find a good aspect in his personality, to value his own hobbies and passions. As Rogers (2008) or Maslow (1954) suggested, therapy should focus on the present, on what can be done with the person and his problem. Personal development was essential, because if Daniel could overcome his negative emotional state, he would be more efficient and pleased with himself. The therapist tried to make him understand himself and his condition. Focusing on patient's person was inevitable, but also choosing what was best for his treatment. Carl Rogers talks about an *"unconditional positive attitude"* that increases self-development, self-esteem and flexibility. Therefore, changes come easier.

The Eriksonian perspective is highlighted by therapeutic stories that knock at the gates of the Unconscious and urges the patient to find alternatives for his problems. An encrypted message is sent to his mind and, therefore, he himself is meant to find a solution for himself, even if he doesn't realize it. If the patient is aware of the message, a reactance phenomenon will occur. Milton Erikson said the patient has enough resources to heal, to solve any problems (Rosen, 1982). Therapeutic change is very important here and is meant to appear when conscious limits are passed. Also, the therapist used several techniques like "Miracle Day" and "Devil's advocate".

Therapy's objectives

Using a graphic representation for the evolution of Daniel's mood, the therapeutic team agreed that the therapy objective would be when a normal

fluctuation around the sixth mark would be reached. We used a scale where score one represented the way Daniel felt in middle school, in the seventh grade, in those critical moments when was mocked by his colleagues. Score ten stating the way he felt at the end of high school graduation.

Steps in therapy

The therapy unfolded during ten sessions. The main therapeutic strategy consisted in organizing a schedule of rewarding activities, using the model of cognitive-behavioral handbooks (Leahy, Holland, & McGinn, 2012). The client has the task of making a schedule which, besides central concerns about studying, must also contain pleasant activities. Daniel's task was to estimate, using the same scale as in mood's graph, the way he believes he would feel during that particular activity. The purpose is to transform this forecasted well-being into self-fulfilling predictions (Dafinoiu, 2001). After putting into practice all programed activities during the week, Daniel added the real mark. He compared the estimation he made and how he actually felt. Indeed, in an overwhelming majority of cases, the scores corresponded or even exceeded expectations.

During the entire therapy, the therapist watched the graph made by Daniel. The line fluctuated in an unexpected way, without significant mood increases that might have indicated maniacal states, but with sudden drops which lasted a short time. This gave the entire graphic a zigzag aspect. The graph didn't correspond to a bipolar type loop.

First session (28th of September 2012)

Psychotherapy began with Daniel's suspicious attitude. He had the need to be reassured on confidentiality. He refused to have the sessions recorded and needed reassurance that he wouldn't be judged: *"Do you think yourself able to understand what I am going to say?"*. His initial attitude might have foreseen problems for self-disclosure. However things changed with time, and the patient was capable of opening himself up in discussions. Daniel said he had visited three different psychologists three times, but these meetings displeased him. This might explain the client's attitude, having experienced some failures in the past. Daniel seemed confused and talked from the very beginning about a large palette of symptoms and thoughts that were waiting clarification. He

seemed, on the other hand, eager for someone to listen, and he talked about his worst events: multiple surgeries and the abuse he took in high school. At the same time, he expressed his preference for Arthur C. Clarke's work *"Space Odyssey"* and also talked about his passion, drawing. Daniel manifested an oscillation between good and bad, between problems and questions, constantly looking for solutions. The therapist identified elements for derealization: *"something is wrong with me", "it's like I am an actor in a scene"*. He stated: *"I don't feel well in my skin"*, which might suggest low self-confidence. He also said he is not very sociable, having two or three friends which he rarely sees. I used the therapeutic story of "*Ly ambassador*" (Burns, 2012) and started a mood graphic.

The 2nd session (5th of October 2012)

During the previous session, the therapist asked Daniel to bring several of his journals. He chose some passages to read and presented some significant dilemmas: (2007) "*What does it mean to be intelligent*?"(2009) "*I feel I am not my own driver*." 2011 "*Time is a friend and a thief*." He stated he had begun the University "*a little bit more peaceful*". During the meeting, Daniel showed emotions of doubt and anger, provoked by the remembrance of his past. In parallel, in the therapist's view there was a possible but quite uncertain diagnosis based on the patient's account. This diagnosis hypothesis remains uncertain and unconfirmed till this present day.

The 3rd session (13th of October 2012)

Daniel talked about his past week's events. He emphasized what happened during two of the days when he was quite *"introspective"*. This suggested that he focused on his own problems, which are typical during breakdown episodes. However, the patient said that negative symptoms and feelings of helplessness had persisted for 7-8 years. This might have been due to a dysthymic disorder. He also complained about feelings of loneliness.

The 4th session (11th of November 2012)

Daniel made his first virtual steps of thinking about the difference between reality and his own thoughts. Also, he hypothesized on his own that negative effects occur if he doesn't physically exercise. This might be an explanation about why he felt without energy the past week. Despite it all, he had a night out with his friends. As homework for the next psychotherapy

session, Daniel was to go out again with his friends and fill in the mood chart. This is a continuation for encouragement, familiarization with some activities and affective state awareness. Awareness of a problem is essential for keeping someone in therapy as well as for the healing processes.

The 5th session (17th November 2012)

The patient highlighted some negative emotions caused by his parents' conflicts. He complained about their distant and cold relationship, lack of communication skills and lack of respect for his privacy. The therapist used the *"Wonder Day"* exercise (Dafinoiu & Vargha, 2005). From this, he extracted several necessary elements in order to get across the concept of a schedule with rewarding activities (Leahy, Holland, McGinn, & 2010). Among the elements of great simplicity present in the description of the Perfect Day there were: morning coffee, breakfast with scrambled eggs and green salad, mint tea, a motorcycle ride, dinner for two and reading newspapers. He also mentioned he would watch a Since Fiction movie called *"Equilibrium"*. The movie is a dystopia about a society where emotion is forbidden. He also included in his Wonder Day a sort of meditation, prana-bindu, found in the novel *"Dune"* written by Frank Herbet. As the client states, practice of prana-bindu is, apparently, a sort of control of the muscles and nerves.

The 6th session (1st of December 2012)

Daniel came in to this therapy session with good news, saying he didn't have episodes when felt spied upon anymore. He started going out with friends again. Using the technique "Devil's advocate", the therapist asked Daniel what he could do to feel worse. He answered that continuing to think about indissoluble dilemmas would certainly make him feel worse. In the rewarded activities written down in his schedule were visits with his best friend, watching movies, coffee with friends, sport and drawing spatial costumes. Daniel also brought in to the therapy session his drawing notebook. Both talked about the drawn costumes. The therapist expressed his preference for some of them, showing marked interested in his talent.

The 7thsession (9th December 2012)

Daniel's emotional state had fluctuated. He made a new friend, but didn't do his assigned homework. He also didn't attend all university classes. It seemed difficult for him to initiate an activity, but more difficult it seemed to

energetically sustain it. He said he had to find inner motivation for the therapy homework and that his interest had *"changed too fast"*. Daniel was told the therapeutic story with *"The old lady and healer"* (Burns, 2012, p. 130).

The 8th session (21st December 2012)

Daniel said he had thought a great deal about the meaning of the *"Old lady and the healer"* story. We discussed about our supposed purpose on this planet: it might be to search for answers for the great questions of Universe, without feeling bad if we couldn't solve all the dilemmas. I explained that humans are historically restless about their existence. The meaning of our existence, the difference between what's real and what's imaginary, the origins of everything, are all philosophical questions. People have been confronting these problems for several thousand years and couldn't elucidate them. It's hard to believe that a single person can discover what others, thousands years ago, couldn't. We are limited beings, and we have to assume that everything that happens to us is real, as long others have same experiences.

The 9th session (2nd of January 2013)

The therapist started with a list of negative and positive events that had happened since the last encounter. Among the negative events was a conflict between Daniel and his parents on 31st December 2012 and mother's medical condition: a pelvic fracture. Among the good things he mentioned the festive atmosphere, the arrival of his brother and decorating the Christmas tree. His brother rarely visits, but his presence usually makes Daniel feel better, despite their distant relationship. We can imagine when Daniel's brother left from holiday, he would feel more insecure, but we can't know this for sure.

The 10thsession (12th of January 2013)

The therapeutic team noticed that fluctuations from the chart were smaller and happened all around the score six. This fluctuation was defined by Daniel as reasonable, in the moment of the therapy's objective settingings. Also, Daniel expressed the wish to end therapy for financial reasons.

Discussion

Generally, medication and anesthesia are avoided in children, because they can affect a person's development. Pain is felt more intensely by children,

but, in the same time, it's all just another unknown experience. From the 1980s, specialists recommended anesthesia for invasive procedures, but some of doctors refused. Pain in infants include, physiologic and metabolic effects: an alteration in the cerebral flow, changes in vital signs, changes in the memory of events, behavioral changes and possible long-term negative effects (Anand & Hickey, 1987). Infants have higher density of cutaneous pain transmitting nerve fibers than adults do (Fitzgerald, 1991). Also, a study has shown that physicians and nurses believed that infants may experience pain as much as adults (Porter, Wolf, Gold, & Miller, 1997). Early-life traumatic stress and pain may contribute to emotional disorders, anxiety and depression, problems in growth and development. Another study on 76 children with heart corrective surgery found a special area of vulnerably in their narrative discourses (Hemphill, Uccelli, Winner, Chang, & Bellinger, 2002). Pain is a subjective construct and is difficult to measure in real life. For this reason, recently the EDIN (Echelle Douleur Inconfort Nouveau-Né, neonatal pain and discomfort scale) scale was created, a clinical practice tool that observes facial activity, quality of sleep, body movement, quality of contact with nurses and consolability (Debillon, Zupan, Ravault, Magny, & Dehan, 2001).

Adolescence is also a difficult period. If negative events occur, mental disorders and affective problems can be present at a later stage. The concept of *"behavior-academic-peer risk"* suggest a type of problem characterized by low peer acceptance, high aggressive behavior, academic difficulties, low academic achievement and increased mental health service use (Valdez, Lambert, & Ialongo, 2011). Persons with depressive symptoms may experience low academic competence, diminished self-worth and negative peer relationships (Ialongo, Edelsohn, & Kellam, 2001). Suicide is the third cause of death among persons aged 15-24 years and suicide accounts for twenty percent of annual deaths in the United States (CDC, 2015). In our case, Daniel started to feel hopelessness (Wilson & Deane, 2009) from age 13-14 years old, complaining about colleagues and teachers in high school.

Parents can influence children, but sometimes children can influence their parents too. We don't know for sure why Daniel's parents behaved this way, and why they had the desire to control Daniel. However, we might infer on the effects of this behavior on their child. He said they had violated his intimacy and had been intrusive. Also, his parents have had many conflicts with each other and have shown a distant relationship with their children. Daniel

might have an insecure attachment (Bowlby, 1988), manifested in adolescence by anxiety and anger. Insecure attachment is associated with paranoid beliefs (Pickering, Simpson, & Bentall, 2008). For instance, a study on adolescents had shown that self-esteem and depressed mood correlated with an adolescent's perception on their parent's behavior (Plunkett, Henry, Robinson, Behnke, & Falcon, 2007). This study revealed that perception of self emerges as individuals interact with their parents. Adolescents who see parents behave with physical affection, encouragement, warmth and praise, decrease their child's risk of mood depression (Garber, Robinson, & Valentiner, 1997).

Depressed persons present automaticity regarding their negative thoughts and become aware only by their effects (Bargh, Chen, & Burrows, 1996). They make significant negative predictions about the future than non-depressive persons. Also, negative emotional feelings generate a displacement and intensification of attention on self (Conway, Giannopoulos, Csank, & Menselson, 1993). The cognitive model of Aaron T. Beck (2008) proposes three types of negative thoughts in depression: thoughts about self, thoughts about one's environment and thoughts about the future. Depressed persons feel negative emotions, such as guilt and hopelessness and believe they are rejected by others. They avoid pleasure and reward. This behavior can have its beginning in childhood. In previous papers, we argued the importance of targeting automatic negative thoughts in depression's therapy (Rotaru, Petrov, & Oprea, 2014).

The theory of resource allocation (Ellis & Ashbrook, 1998) shows that negative emotional feelings reduce the resources that can be used for a specific task, because they are associated with congruent emotional thoughts which are brought about in consciousness (Howell & Conway, 1992). This includes many attempts of understanding and adjustment of an individual's own emotions and strategies that consume their attention resources. In our case, Daniel is occupied most of his time with his own thoughts and isn't able to start some activities from his own initiative. These thoughts generate specific feelings in Daniel.

Negative states also generate an altered perception of time (Kuhbandner et. al., 2009). Time is slow, because identification and processing of external stimuli is faster. On the other hand, when persons have positive feelings, time is perceived as moving faster. Our patient said in his 2007 diary: *"Time is a friend and a thief"*. This shows his interest when it comes to perception of time. Also, the negative states induce an informational "bottom-up process", fixing

attention on situation details and limiting mental associations (Jefferis, Smilek, Eich, & Enns, 2008). Depressive and anxious people often remember negative experiences (Clark & Teasdale, 1982; Deny & Hunt, 1992). Emotion has an influence on memory, as shown in a study on persons with clinical depression (Bradley & Mathews, 1983).

A cognitive therapy prevention program in school has been shown to be effective in minimizing negative thoughts and depressive symptoms (Lewinsohn, Rohde, & Seeley, 1998). For youth depression, psychotherapy also reduces the symptoms (Weisz, McCarthy, & Valeri, 2006). Cognitive therapy seems efficient too (Butler, Chapman, Forman, & Beck, 2006).

Many authors like Sigmund Freud, Jean-Pierre Charcot, Pierre Janet suggested that a consequence of trauma is division of personality. The first studies about trauma and dissociative experiences were shown in retrospective investigations (Boon & Draijer, 1993; Chu & Dill, 1990; Coons, 1994; Nijenhuis, 2000). Daniel manifests derealization symptoms, a sort of dissociative experience. These symptoms include feelings of déjà-vu, the impression that things around him might not be real. He is anchored in science fiction imagery, draws spatial costumes and doesn't seem to foster a feeling of self-control. In the beginning, he is a little scared by all these feelings of derealization, but at the end of therapy, he started to see these symptoms as normal. Many studies have shown a positive correlation between trauma and dissociative experiences (Chu & Dill, 1990). The patient *"retreats from the field of consciousness"* (van der Kolk, Brown, & van der Hart, 1989). He wants to forget all negative events and build an alternative reality in order to escape. Other studies have revealed that persons who had traumatic events during childhood are predisposed to psychological or mental disorders, including mood and anxiety disorders, eating disorders, psychosis, dissociative disorders and substance dependence (Kindler et al., 2000; MacMillan et al., 2001; Nelson et al., 2002; Janssen et al., 2004).

The patient reported several headaches. A study showed that self-reported severe headache pain was associated with higher levels of depression. Also, strong coping skills might reduce depression among headache suffers. Sternbach and colleagues (1980) found psychological differences between headache types and concluded that differences were likely due to the frequency and duration of pain-free intervals. Also, they say psychological symptoms might be the result of living with recurrent pain rather than the cause of pain.

Recurrent headaches were significantly associated with symptoms of anxiety and depression as well as attention difficulties in persons between 15-17 years (Blaauw et al., 2014).

From an Eriksonian perspective, the therapist was limited, because he couldn't use hypnosis. Supposed psychotic elements might have made this endeavor a risky one. From the very beginning, patient refused to have his therapy sessions recorded. This prevented other elements or new interpretations from being done based on recordings.

The therapy ended due to financial reasons, but other fields of Daniel's experience could have been explored. The patient had several problems, but the therapy's objective was his emotional state. If we had worked on other objectives, it's possible that the patient would have had a different evolution. It's also true that patient refused his parents' presence in therapy. Considering that his parents had many conflicts, a suggestion would be for them to use couple therapy. If a parents' problems are to be solved, it is possible that a patient's emotional state could improve even further. Last, but not least, the patient's account was very complex and didn't fit into a DSM-IV-TR diagnosis. This might illustrate that the entities described in psychopathology do not account for all the idiosyncrasies, and that a diagnosis label might not be needed in order to properly intervene, even when symptoms seem severe.

Client's post-therapy evaluation and follow-up

Six months after the therapy ended, the therapist called Daniel. He declared himself satisfied with the results of the therapy, thought it was a good idea to visit a specialist and that the therapy had helped him a great deal. He said he felt around "six "most of the time. There were rare moments of despair, but the episodes when he had felt watched completely disappeared. He was having more frequent meetings with people, although he hadn't made new friendships. He didn't have, yet, a partner or sexual one. He continued to be focused on his University exams and performance, continued to exercise and described the way he felt by using the word "stable". Daniel declared that psychotherapy helped him very much and was thankful he had made the decision not to think of things that are *"far from reality"*. Sometimes he said he had derealization episodes, but they didn't scare him as much as they did in the past.

After two years and three months since the conclusion of the therapy, the therapist contacted Daniel over the phone again. His situation had markedly improved. He was happy to report that his mood was *"a definite eight".* He had finished University with good grades and was now enrolled in a master's program. He has already received a job offer from abroad, for a prestigious car manufacturer, but he declined, wishing to continue his studies. He has been going out more often and works-out in the gym. When asked about a partner, he said *"This project is still in progress".* His parents, especially mother, is still described as intrusive and unable to respect his privacy, but Daniel has his own mobile phone number now. He asked the therapist again whether the phone discussion was confidential. When asked *"To whom do you think I might say something, Daniel?"* the ex-client stated that the therapist might discuss this with the psychiatrist. Daniel was reassured that the psychiatrist would not know about this conversation. This last exchange further emphasizes that the lack of trust Daniel has in people might have some structural basis. His personality, although adapted, seems borderline distrustful about other people.

Conclusions

Daniel's case, remains for the therapist an enigma, not concerning the psychotherapeutic outcome or techniques but more about the validity of conceptualizations and the possible diagnosis (if any). Although the therapist involved the psychiatrist, the psychiatrist didn't find satisfactory nosology categories to fit Daniel in. The client had received the instruction to call the therapist often in order to tell him about how he felt. Daniel respected this task. His emotional state remains satisfactory, and his situation is markedly improved after two years since the therapy ended. This might suggest that the therapy's outcome was stable and efficient, despite the uncertain supposed psychopathological background. It's clear that other extra-therapeutic factors participated to this improvement. Psychotherapy seems to have reached this purpose. The therapist declared himself reserved about the stability of results after the first follow-up discussion, but is more optimistic after the second one. The cycle of adaptive changes seems to have begun.

The supposed presence of psychotic elements makes the story about Daniel's evolution hard to believe. It is possible that endogenous elements generated by earlier medical history are partially responsible for Daniel's

emotional states. Patterns of apparent mood cycling, without hypomanic liftings of thymia, don't correspond with what is found in the specialized psychopathology literature. Daniel responded more to cognitive and behavioral interventions, the offer of a positive unconditional image, but he refused the idea of medication. It's true that the intrusive behavior of his parents discouraged Daniel's autonomy. However, any element from this context doesn't explain the evolution and the emotional states described by him. After two whole years since the therapy ended, Daniel's situation is further improved. He is convinced therapy gave him a helping hand. This case is illustrative for apparent stable results in the absence of a certain diagnostic clarification that may account for the symptoms and signs that were described at the very beginning of therapy.

Limits

This present case study describes a series of conceptualizations and eclectic interventions, in the context of a diagnostic uncertainty. The extent to which all the presented interventions are responsible for change is uncertain, especially in the light of an uncertain nosology fit. Moreover, the illustrative value of this case study doesn't allow for generalizations, as in the case of quantitative systematic research. The purpose is to reflect over the various models used in conceptualizing this case, so they serve as a source for a new hypothesis and to present some of the fine and idiosyncratic nuances that are particular to psychotherapy (Sava, 2003). Last but not least, this case can serve as didactical support for a therapists and psychiatrists in training, in order to confirm or challenge the presented ideas. Better explanations and intervention ideas can be proposed on this case and can be used in similar situations in psychotherapy. Systematic future research can separate the various pairs of diagnosis-intervention with the purpose of testing the efficiency and reliability of the diagnostic and therapeutic processes. Moreover, controlled clinical trials can study the added effect that another conceptualization, like the systemic one as well as associated intervention; these can be brought in for the benefit of the client.

Ethical aspects

All the names used in this study are fictitious and the client's identity is protected. The presented case is real. Names and all other information

concerning identity have been slightly modified in order to make it impossible for the readers to identify this person.

Acknowledgement
This work was financially supported by the project: „Program of excellence in doctoral and postdoctoral multidisciplinary research in chronic diseases, contract no. POSDRU/159/1.5/S/133377, beneficiary U.M.F. "Gr. T. Popa" of Iaşi, project financed by the Social European Fund through the Operational Sectorial Program for Human Resources Development 2007-2013".

References

Beck, A. T. (2008). The Evolution of the Cognitive Model of Depression and Its Neurobiological Correlates. *The American Journal of Psychiatry, 165*(8), 969-977.

Anand, K. J. S., & Hickey, P. R. (1987). Pain and his effects on the human neonate and fetus. *New England Journal of Medicine, 317*, 1321-1329.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th Ed.). Washington, DC.

Bargh, J. A., Chen, M., & Burrows, L. (1996). Automaticity of social behavior: Direct effects of trait construct and stereotype activation on action. *Journal of Personality and Social Psychology, 71*(2), 230-244.

Blaauw, A. B., Dyb, G., Hagen, K., Holmen, T. L., Linde, M., Wentzel-Larsen, T., & Zwart, J. (2014). Anxiety, depression and behavioral problems among adolescents with recurrent headache: the Young-HUNT study. *The Journal of Headache and Pain*, *15*, 38.

Bradley, B. P., & Mathews, A. (1983). Negative self-schemata in clinical depression. *British Journal of Clinical Psychology, 22,* 173-181.

Boon, S., & Draijer, N. (1993). The Differentiation of patients with MPD or DDNOS from patients with A cluster B personality disorder. *Dissociation, VI*(23), 126-135.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.

Burns, W. G. (2012). Stories in psychotherapy. In N. M. Seel, (Ed.), *Encyclopedia of the Sciences of Learning* (pp. 3195-3196). New York: Springer.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical Psychology Review*, *26*(1), 17-31.

Center for Disease Control and Prevention, National Center for Injury Prevention and Control. Web Based Injury Statistics Query and Reporting System (WISQARS) (n.d.). retrieved from www.cdc.gov/injury/wisqars/index.html [accessed April 23, 2015]

Chu, J. A., & Dill, D. L. (1990). Dissociative symptoms in relation to childhood physical and sexual abuse. *American Journal of Psychiatry, 147*(7), 887-892.

Clark, D. M., & Teasdale, J. D. (1982). Diurnal variations in clinical depression and accessibility of memories of positive and negative experiences. *Journal of Abnormal Psychology, 91*, 87-95.

Coons, P. M. (1994). Confirmation of childhood abuse in child and adolescent cases of multiple personality disorder and dissociative disorder not otherwise specified. *Journal of Nervous & Mental Disease, 182*, 461-464.

Conway, M., Giannopoulos, C., Csank, P., & Menselson, M. (1993). Dysphoria and specificity in self-focused attention. *Personality and Social Psychology Bulletin, 19*, 265-268.

Debillon, T., Zupan, V., Ravault, N., Magny, J., Dehan, M., & Abu-Saad, H. (2001). Development and initial validation of the EDIN scale, a new tool for assessing prolonged pain in preterm infants. *Archives of Disease in Childhood. Fetal and Neonatal Edition, 85*(1), 36-41.

Dafinoiu, I. (2001). *Elemente de psihoterapie integrativă* [Elements of integrative psychotherapy]. Iași: Polirom.

Dafinoiu, I., & Vargha, J. L. (2005). *Psihoterapii scurte* [Short psychotherapies]. Iași: Polirom.

Denny, E. B., & Hunt, R. R. (1992). Affective valence and memory in depression: dissociation of recall and fragment completion. *Journal of Abnormal Psychology, 101*, 575-580.

Ellis, H. C., & Ashbrook, P. W. (1998). Resource allocation model of the effects of depressed mood states on memory. In K. Fiedler, & J. Forgas (Eds.), *Affect, cognition and social behavior*. Toronto: C. J. Hogrefe.

Fitzgerald, M. (1991). Development of pain mechanics. *British Medical Bulletin, 47*, 667-675.

Garber, J., Robinson, N. S., & Valentiner, D. (1997). The Relation between Parenting and Adolescent Depression Self-Worth as a Mediator. *Journal of Adolescent Research, 12*(1), 12-33.

Hemphill, L., Uccelli, P., Winner, K., Chang, C. J., & Bellinger, D. (2002). Narrative discourse in young children with histories of early corrective heart surgery. *Journal of Speech, Language, and Hearing Research, 45*(2), 318-331.

Howell, A., & Conway, M. (1992). Mood and the suppression of positive and negative self-referent thoughts. *Cognitive therapy and research, 16*, 1-21.

Ialongo, N., Edelsohn, G., & Kellam, S. G. (2001). A further look at the prognostic power of young children's reports of depressed mood. *Child Development, 72*, 736-747.

Janssen, I., Krabbendam, L., Black, M., Hanssen, M., Vollebergh, W., de Graaf, R., & van Os, J. (2004). Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatrica Scandinavica, 109*(1), 38-45.

Jefferies, L. N., Smilek, D., Eich, E., & Enns, J. T. (2008). Emotional valence and arousal interact in the control of attention. *Psychological Science, 19*, 290-295.

Kuhbander, C., Hanslmayr, S., Maier, M. A., Pekrun, R., Spitzer, B., Pastotter, B., & Baum, K. H. (2009). Effects of mood on the speed of conscious perception: behavioral and electrophysiological evidence. *Social Cognitive Affective Neuroscience, 4*(3), 286-293.

Leahy, R. L., Holland, S. J. F., & McGinn, L. K. (2012). *Treatment Plans and Interventions for Depression and Anxiety Disorders*. New York: Guilford Press.

Lewinsohn, P. M., Rohde, P., & Seeley, R. J. (1998). Treatment of adolescence depression: Frequency of services impact on functioning in young adulthood. *Depression and Anxiety, 7*, 47-52.

Maslow, A. H. (1954). *Motivation and personality*. New York: Harper & Row Publishers.

MacMillan, H. L., Fleming, J. E., Streiner, D. L., Lin, E., Boyle, M. H., Jamieson, E., Duku, E. K., Walsh, C. A., Wong, M. Y., & Beardslee, W. R. (2001). Childhood abuse and lifetime psychopathology in a community sample. *American Journal of Psychiatry, 158*(11), 1878-1883.

Nelson, E. C., Heath, A. C., Madden, P. A., Cooper, M. L., Dinwiddie, S. H., Bucholz, K. K., Glowinski, A., McLaughlin, T., Dunne, M. P., Statham, D. J., & Martin, N. G. (2002). Association between self-reported childhood sexual abuse and adverse psychosocial outcomes: results from a twin study. *Archives of General Psychiatry*, *59*(2), 139-145.

Nijenhuis, E. R. S. (2000). Somatoform Dissociation: Major Symptoms of Dissociative Disorders. *Journal of Trauma & Dissociation*, *1*(4), 7-32.

van der Kolk, B. A., Brown, P., & van der Hart, O. (1989). Pierre Janet's Treatment of Post-traumatic Stress. *Journal of Traumatic Stress*, *2*(4), 365-378.

Pickering, L., Simpson, J., & Bentall, R. P. (2008). Insecure attachment predicts proneness to paranoia but not hallucinations. *Personality and Individual Differences*, *44*(5), 1212-1224.

Plunket, W. S., Henry, S. C., Robinson, C. L., Behnke, A., & Falcon, C. P. (2007). Adolescent Perceptions of Parental Behaviors, Adolescent Self-Esteem, and Adolescent Depressed Mood. *Journal of Child and Family Studies*, *16*(6), 760-772.

Porter, F. L., Wolf, C. M., Gold, J., Lotsoff, D., & Miller, J. P. (1987). Pain and pain management in newborn infants: A survey of physicians and nurses, *Pediatrics*, *100*, 626-632.

Rogers, C. R. (2008). *A deveni o persoană* [Becoming a person]. București: Trei.

Rosen, S. (1982). *My voice will go with you. The teaching tales of Milton H. Erikson*. Now York: Norton.

Rotaru, T. S., Petrov, I., & Oprea, L. (2014). A short psychotherapeutic intervention on depression complicated by a chronic B virus infection: a case study. *Journal of Psychological and Educational Research*, *22*(2), 102-115.

Rotaru, T. S., & Petrov, I. (2014). Short psychotherapeutic intervention on pathology borders and fight for power: A case study. *Journal of Psychological and Educational Research*, *22*(1), 57-71.

Sava, F. A. (2013). *Psihologia validate ştiinţific: ghid practic de cercetare în psihologie* [Scientifically validated Psychology: A Practical Guide to Research in Psychology]. Iași: Polirom.

Sternbach, R. A., Dalessio, D. J., Kunzel, M., & Bowman, G. E. (1980). MMPI Patterns in Common Headache Disorders. Headache. *The Journal of Head and Face Pain*, *20*(6), 311-315.

Valdez, C. R., Lambert, S. F., & Ialongo, N. S. (2011). Identifying patterns of early risk for mental health and academic problems in adolescence: A longitudinal study of urban youth. *Child Psychiatry & Human Development*, *42*(5), 521-538.

Weisz, J. R., McCarthy, C. A., & Valeri, S. M. (2006). Effects of Psychotherapy for Depression in Children and Adolescents: A Meta-Analysis. *Psychological Bulletin, 132*(1), 132-149.

Wilson, J. C., & Deane, P. F. (2009). Help-negation and suicidal ideation: The role of depression, anxiety and hopelessness. *Journal of Youth Adolescence, 39*, 291-305.

Received May 12, 2015
Revision October 15, 2015
Accepted November 17, 2015