Journal of Diagnostics
2017 Vol. 4, No. 1, pp. 13-28
ISSN(e): 2409-322X
ISSN(p): 2413-8371
DOI: 10.18488/journal.98.2017.41.13.28

MAJOR DEPRESSION WITH DELUSIONAL PREVALENCE AND FIXATION ON NEUROTRANSMITTERS

Trifu Simona[1+]
Teodorescu Andreea[2]
Voinescu Loredana Lusia[3]
Carp George Eduard[4]

[1]*University of Medicine and Pharmacy "Carol Davila", Bucharest, Romania*
[2,3]*University of Bucharest, FPSE, Bucharest, Romania*
[4]*Hospital for Psychiatry, Sapunari, Romania*

(+ Corresponding author)

Article History
Received: 26 June 2017
Revised: 27 July 2017
Accepted: 9 August 2017
Published: 28 August 2017

Keywords
Schizoaffective disorder
Paranoid schizophrenia
Hypersensitivity
Prevalence
Psychotic episodes
Neurotransmitters.

ABSTRACT

Making a differential diagnosis between schizoaffective disorder with major depressive episode and paranoid schizophrenia is difficult. The patient is at the threshold of neurotic versus psychotic, the intensity of ideation phenomenon being very high and specific to both disorders, it is required an assessment based on life and disorder history information, but also the emotional presence of the patient in the clinical interview. In this case study we suggest a literature comparison but also an evaluation profile of the disorder, marked by a psychiatric illness in which the person shows both affective symptoms (depressive or maniac) and symptoms of schizophrenia (such as delusions, hallucinations). Hypothesis: symptoms of the patient are oscillating between paranoid elements (paranoid schizophrenia) and affective elements (schizoaffective disorder). These oscillations are based on a fragile Ego structure with cognitive rigidity. The study outlines an immature-dependent personality profile, based on interpretativity, with passive-aggressive elements, hypersensitivity, psychotic operation and through psychotic elements manifested in the past (auditory hallucinations, as voices). Also, the basis of the transfer and counter-transference elements identified, the emotional resonance is low, with a risk of psychotic decompensation. Conclusions: Depressive schizoaffective disorder is characterized by presence of both depressive and schizophrenia symptoms in the same time period. Depressive symptoms includes: depressed mood, reduced interest, sluggishness, low energy, difficulty concentrating, insomnia, feelings of despair. During the same episode are present symptoms of schizophrenia: hallucinations, delusions of control, state of hyper-vigilance, delusions injury. Clinical examination cannot be a chance encounter because the history of mental suffering tight interfere with subject's essential history in that it creates a gap and that subjectivity psychiatric symptoms inferred immense emotional and personal participation of the subject.

1. INTRODUCTION

A. Patient Identification Data

The case regards a female patient named M., 40 years old with master degree in medical field, working as teacher of biology at gymnasium. Currently she do not work. The current pharmaceutical treatment: Venlafaxinum, Olanzapine (is under medication being given Escitalopram and effective (antidepressants))

B. Reasons for Attending Psychotherapy

The patient claims that she has a pronounced state of agitation and compulsive eating disorder (looking for "drugs" to make him happy: sweets, sausages, cigarettes) and the impossibility of having any other activities

(accused of being unable to focus and learn for exams) and responding to social requirements - she gave up work, started master degree, but she has difficulty performing tasks (affected memory), including housekeeping (she does not find energy to eat, clean).

She complains about the effects of the antidepressants he is taking, which she considers responsible for the emotional state in which she is (she does not feel like he was at the beginning, before the depression and blame the pills for her actual condition, accuses feelings of rage and exaggerated nervousness, sensitivity to rejection, hypochondria - an exaggerated fear of getting sick, high inner agitation, and permanent fear).

C. Patient Speech

The patient started by complaining that she can't sleep, that she's falling asleep very hard, the sleep is turbulent, with dreams, and she's blaming this on the drugs (sleeping troubles, sleeps hard, waking up few times a night, turbulent sleep, dreaming weird stuffs, insomnia). She's eating to be able to calm down, which helps her to fall asleep. She's complaining that she's thinking only at bad stuffs and that she's eating a lot of chocolate, smoking cigarettes on and on. She's eating sweets and food during the night, after midnight, and food by night and during the day. (Eating problems, searching for "drugs" which give her pleasure: sweets, sausages, cigarettes). She's complaining about bad thoughts ("I'm thinking only about bad stuffs") and about the fact that the drugs don't have the same effect ("What happened with them, with the drugs? They're not like in the first week.")

Unpleased by the drugs, she is not feeling like in the beginning, she's blaming the pills for the feelings that she gets. She's complaining that she can't study ("I can't study. I'm looking in the papers, is a helplessness that i observed since September") she's blaming the helplessness that she's unable to focus and study for the exams. "I can't go to school, I can't do things" and that this helplessness feeling lasts already for more weeks. She's relating a story in which she's finding an excuse to miss a seminary course (she's studying for masters) where she had a presentation in front of the colleagues ("I run away from the presentation, for masters. When I saw so many colleagues..."). The feeling of agitation is demonstrated also by the "weird" dreams that she presumes she has.

She's very interested and she keeps coming back to this subject with the therapist, of the drugs effects over her nervous system and keeps coming back with questions about their functions, having a speech as she would be reading from books: „the role of the serotonin in the reward system" ,"the noradrenaline got too high?". She's complaining that she's not doing what she should do, and that she's doing only things that she likes to do, presenting this as it would be something negative. She keeps coming back to the questions about the drugs ("The noradrenaline got higher from the Venlafaxinum? With Escitalopram it was good but I was not pleased. I don't feel any pleasure anymore now."). She associates her compulsion with activities that are pleasant with a drug: massage, chocolate, cigarettes ("I'm like a drug addicted drug seeker." "I'm always looking for the drug to please me)" (looking for "drugs" It causes pleasure: sweets, sausages, cigarettes).

Newly comes back with the question: "Has adrenaline grown too much?" Tells an experiment in which a mouse pushes a pedal and unloads oxytocin until the mouse dies. She complains that she is eating sausages because they have glutamate (glucose) and that she does not feel good within her ("I do not feel well inside") (she does not feel good inside, she is afraid, lack of libido). She says, as a kind of reproach to her husband, that he understands that she tells him to leave the unfulfilled things, because he does things easily, but that she does not rejoin herself ("I do not recognize myself"). She asks for a precise diagnosis, but she prefers something other than the one she has already received (major depression), which she calls into question, declaring herself dissatisfied. She says she has irritability and aggression, and periods of crying and she's unable to get out of bed, and exaggerated nervousness. She no longer bears the noise, she sleeps with ear plugs, and any noise is heard in the apartment irritates her that she does not know what to do. (Accusing aggression and exaggerated nervousness, irritability, sensitivity to rejection).

She continues to put the states she has on neurotransmitters ("Is depression so aggressive? Anything trigger my nervousness, does that mean I have too much noradrenaline?"). It turns to the comparison between useful and pleasant: "Before things were not pleasuring me." She complains about social isolation ("Staying, hiding, eating, and not interacting with people ...") a pathogenic dimension of social withdrawal (not to get out of bed and not take care of personal hygiene - social isolation). It reappears in the discourse the substances fixation ("Why you did not give me Escitalopram then?") And the doubt about the diagnosis (catastrophic vision of diseases) Lists more names of psychiatric disorders and symptoms, as well as reciting the treaty: obsessive-compulsive disorder, mood disorder, agitation.

It mixes these terms with descriptions of her psychic states that push her to consult many physicians, like looking for the one that will confirm what she has in her mind ("I had something hard and I was going to look for it" "I came to the doctor who said that i have obsessive-compulsive disorder, because I go to all sorts of doctors. "" How did I come to you as schizophrenia? "). Expresses also fear behind these states and behaviors: ("Perpetual fear inside that I have something serious"). (Is afraid of the psychotic plane, asks if there is schizophrenia). Although she complains that she cannot get out of bed, and that medications (Valdoxan) have lowered her libido, she adds that she has an internal state of intense agitation that affects her self-esteem ("How should I be? Who am I? That I do not know where I am in such a mood ... "). (She does not feel good inside with her, she is afraid, lack of libido) It puts on the medication the loss of libido and the damage of memory ("It has affected my memory, which one of them?" "Who did this?" Which drugs?) Trying to argue so, by the affection of her functioning, the desire to not take any medication. ("There is no way I cannot take a medicine, right?"). Puts on the relationship with her mother, something heard from other doctors, as they say, that she has this behavior. ("This is my condition under which I'm taught to work, it's learned from parents, from my mother, so a doctor told me.") Then she insists on seeking explanations from doctors and books without authentic introspection. Relationships with parents and brothers: She has a younger sister who gets her jealous (since she appeared her parents neglected her, they are speaking proudly about her sister, and about her they are laughing and telling all the silly things; they helped the younger sister from the first to go to Law and they didn't allowed her to go to college, she had to stay in hospitals from where she can forget the bad smells => discomfort).

She feels unable to cope with the demands of her studies and compares her incapacity with her mother's incapacity ("That's the way she was." "My father did everything." "My husband does everything - he made my presentation" "In my time we were learning the subjects, presentations are now being made ... "). She repeatedly breaks the introspective discourse into the role of substances in the body. ("Do you think norepinephrine is also needed?"), Looking like a charmed substance to help her adapt ("How do should i do? How should i do to learn")

She has major ideas centered on her functioning, her psyche and neurotransmitters. She continues to complain that she cannot ("I went to the doctors and asked them for drugs"). She denies the psychological causes of her states by putting them at the heart of neurotransmitters, who in her speech seem to be responsible for everything that happens to her ("That's dopamine, not psychotherapy!"). She has major ideas centered on her functioning, her psyche and neurotransmitters. At the same time, however, she is afraid to take medication, probably afraid of becoming addicted or associating with mental illness, which she seems to be very afraid of ("I do not want to take drugs! I came here because i am unpleased! Maybe I had reasons to be so."

Unpleased by the medication, she no longer feels like it first, blaming the pills for the states that she has. She returns on blaming her mother and sister for the current state ("Who knows what my mother did in my childhood? I think my sister appeared maybe I was not in the spotlight anymore. They were praising her, not me. She was good, I was... ") It seems she did not feel loved by her mother during her childhood. (Relationships with parents and brothers: she has a younger sister she is jealous of (since she appeared her parents have neglected her about her sister they are speaking with pride, and about her they are laughing and telling silly things, they helped the

younger sister to go to Law and she was not allowed to go to college, she had to stay in hospitals where were bad smells => discomfort).

She tells that as a traumatic experience as in the first year of high school she practiced (nursing) in the hospital, in gynecological operations, where she was asked to stay at the resuscitation section next to the gems that were operated and where she had to encourage (" I had to sit with the women to tell them "Breathe! Breathe! Breathe!" This is to be a nurse, to stay near the sick. I saw a lot of there: probes from bearded, urethral, I came to suffer, a child, at the age of 14. ") She is self-pacing for traumatic experiences in the hospital at a very early age. She returns to her parental treatment in childhood, telling that she felt humiliated by them, and accused of evil intentions toward her sister. ("I was laughing at stealing the younger sister's milk, I was going to let her without and I wanted to do something to her."

She then reports that her mother was taking her to a doctor, and that this is the form of affection she learned from her mother who was taking her everywhere because she was very cold and carried her to a phenomenologist, a dentist, a gynecologist(„This is how I see the affection, that the doctor cares for me"). She says she is now going with her husband, even at the gynecologist, as if repeating the mother's rituals from childhood.

She expresses doubts about this self-image she seems to have perceived from her mother ("Maybe it's not like that. It's kind of stupid when someone tells you the in first.") The unfortunate story (childhood story, story of the bottle that was told by the parents, the younger sister and more appreciated by the parents, the mother who did not pay attention, the list of failures and the problems with envy). Thus, she says that repeated visits to a doctor are a search for the affection, questioning the mom's actions and stories ("Maybe is not like that."), maybe she was not bad with her sister, maybe there was nothing wrong with her and it would not have been necessary to go to all sorts of physicians). Perhaps it is not true that she was stealing something from her sister, in the supposedly the idea that the others actually steal from her, that things are exactly the opposite. (It is in identification with my mother, "I first thought I had a polyarthritis like my mother")

She comes back with ideas about the lack of professional activity - she was a biology teacher at the gymnasium, but she did not face it and gave up working for fear of being aggressive with the students ("I was disturbed that I left school this year. I hate the children, I was going to clutch their throat to keep them quiet, I took a sabbatical year. ") These thoughts scare her and make her think of the worst (" These are thoughts of schizophrenia? At what age can schizophrenia begin? " (Asks if she has schizophrenia because at one point she was going to clutter the throat of the children when they were making noise). And it compares the possibility of having the most serious physical illness, with the fact that around her she sees a lot of people with the most serious somatic disease - cancer. ("I saw only cancer around, it's like no one dies by car ..." "No one dies but by this sickness, and in psychiatry by schizophrenia") (She's afraid of the schizophrenic plan) [1].

She seeks the psychiatrist to confirm that she has the most serious illness, as from other doctors she seeks confirmation that she has the most serious medical condition in which her physician is specialized.

The patient remembers seeing a street man in the cold winter, a street man whom she calls as being schizophrenic, and that she was amazed that he was alive ("It was a schizophrenic naked in the middle of winter on the street. He was full of life in it, and how fragile it is in others ... ") She is commenting on the fact that the current drug treatment is not an indication of schizophrenia, these are not drugs that are given in this disease. She returns to her quest for pleasure in everything she does, and says she has no energy to do things that would please others ("I have no energy to please. I have the energy to look for pleasure.") (Low energy and state fatigue) Put that helplessness on drugs again ("Second time why did not I respond to Valdoxan? Should I take something else?") She remembers the comment of a doctor who told her that she would even listen to her cells. ("A doctor told me I was listening to my cells").

Her psychological processes appear to be localized at the cellular level where the substances act, as if trying to push the psyche into the somatic. It denotes great vigilance in body screening.

She comments that going to a doctor and doing all sorts of analyzes gives her a sense of tranquility of the state of inner agitation, the "anxiety" she always feels like a weight ("If I do my analysis at it says nothing is wrong, I'm fine."). She recounts that at night when she is in bed she hears neighbors talking in their apartments that she seems like hallucinations, but checks the truth of her sensations asking her husband if he too hears them, and that this confirms that indeed, the neighbors do speak. ("I ask my husband, I'm sure I hear, or do I ... have hallucinations?")

She compares herself with a baby very sensitive to noise and light, describing her sensory hyper vigilance. She says she has a "hypersensitivity to the senses," it needs to be very quiet and very dark (pulls the drapes in the evening at bedtime, though it's dark outside). (She says she does not have delusions and delusional ideas, but she has prevalence.) She cannot take the noise, she sleeps with earplugs, and when any noise is heard in the apartment that irritates her, she does not know what to do.)

The patient begins to describe an ideal self-image to which she aspires: "A 40-year-old woman must be strong." There is a lack of meaning in her speech: What's the point of being in depression? What's the point of examinations? What does it mean to be skinny? I rumble all day ... "Here is the lack of meaning, another sign of major depression. The internal pressures associated with these rumination make it wonder if they are normal questions.

At the intervention of the therapist who tells her that her energy is stolen by her ruminant thoughts, she continues to say she cannot make food, clean, because she does not find the energy she needs for these things ("I cannot do anything from me. Food , clean ... ") (lack of interest and pleasure, low energy and fatigue).

She says she has energy, but she cannot turn it into useful activities, but only in actions to search for "the drug," of pleasure. She lists the things that make her happy ("the night through the refrigerator, the TV, something nice.") And how the behavior is manifesting the agitation through insomnia and the fact that she feels to do something all the time ("Why do I only grab at night?, I'm looking to go. I have something to go, probably to consume my energy ").

It seems that using the term "drug" refers to pleasant activities, but at the same time breaking the reality.

Although it can be seen from the discourse that the reference is indeed to substances: food, chocolate, nicotine, drugs, adrenaline, noradrenaline, cells, they all seem to be at the service of isolation from a reality in which they feel deprived and stolen by others. (Looking for "pleasure drugs": sweets, sausages, cigarettes) and sleep problems (sleeping hard, waking up a few times a night, restless sleep, dreaming strange things, insomnia)

Again, the thought of the internal agitation she is struggling with reminds her of the depression medications she takes that she takes to calm herself, and she's asking herself about the side effects ("It has affected my circuit pleasure? "). Does he seem to associate depression with a state of agitation ("Is it depressed?") And again attempts to argue for not wanting to take them ("If I do this by will, do you remove the Olanzepina?"). But it is lost again, in the pack of neurotransmitters.

She reports that she has taken a three-month treatment with glucocorticoid-based asthma, and associates treatment with the onset of depression ("What if the three months of Seretide started depression? Did the hypothalamic axis disrupted?) Interestingly, it looks like it's looking to ingest drugs that act on the nervous system, even when it comes to other conditions.

She was treated for three months with Seretide, two puffs twice a day, and wondered if this drug had "suppressed immunity".

It transcends here the high reactivity on the body-psyche balance. (It does not feel like it first, she blames the pills for the states she owns) Immediately compares with her mother who has done endocrinology medical checkup ("They looked upon my mother's pituitary too at Parhon Endocrinology Hospital, found her with rheumatoid arthritis").

She is in identification with her mother (the first time I thought I had polyarthritis like my mother) She says her mother was diagnosed with the Hashimotto thyroid, that she had high FSH, big LH . And she wonders what was first, as if one was to determine the other.

Clearly, she believes that all things are related to the action of substances in the body and that depression is a collateral effect of medication treatments, adding that her mother also has a depression after the treatment received at Parhon Endocrinology Hospital . As if going to a doctor with the mother in childhood for various illnesses (the way she received maternal affection, so her mother) was the main cause of her acute illness or, in other words, the maternal affection she received in childhood was poor, of poor quality, as a result of its origin, birth in the wrong family, with inappropriate and inappropriate parents, would be guilty of a predestination of her unhappiness and failure in life. It leads to predestination and lack of hope, explains the feeling of helplessness.

It leads to predestination also the lack of hope, explains the feeling of helplessness. Nothing can be done, because things cannot be changed, we cannot change our parents. With emphasis she adds that she is severely deficient in vitamin D2 and takes Vigantoletten (a vitamin D2 solution that is given to children up to 7 years and only for specified periods).

Then she treats herself as a very small child with substances, trying at the same time to give herself a mature aura of science, "I know what I'm doing, I'm a great man, and the big people do that, they treat serious diseases." She tells that at the time her mother treated her rheumatoid arthritis, her hands and legs were hurting her too, and she thought she had polyarthritis.

It seems to be in competition with her mother, who is more seriously ill, denying her mother the right to be sicker than her, because then she would take her out of the role of a helpless child, taken to the doctor by her mother, which would change the unconscious pattern of operation. We can also recognize here a hysterical mimicry. And she immediately adds that "Mother has depression," deducting that the treatment for polyarthritis caused depression to her mother. (The patient is present in psychiatry with a psychiatric history and family history (anxious-depressed mother)

She admits she is angry, implicitly to her mother she was just talking about, saying, "If reality was what I wanted, I would not have had reasons to be upset." This is the last thing the patient says at the end of this speech fragment in which she overlaps her own image with that of her mother chewing them (identification).

This segment of speech is followed by the description of an ideal self, namely: being more sociable, the well-being of the massage salon (it is deduced that it she is the owner of a massage salon and that it she has difficulties in managing this business) can support it herself, because the husband is currently the one who supports it, and says that if the husband would not support it, the closure of this salon would be "another failure" in addition to what has been accumulated so far (the inability to keep her position as a teacher , the inability to support college presentation, the inability to do useful things, the inability to work without medication, the inability to be born of a dishonest mother who is now trying to deprive her the right to be herself the sick daughter , - infant mechanism to draw attention to one's own person).

The patient recalled that she had "been defeated" by a student she had meddled in the past which became a teacher at a post-school school, and she feels humiliated by this situation, being just a gym teacher while her student arrived on a higher post because she had relations (or she is from the right family, not because she would have been more capable professionally than the patient); ("She is teaching where I always wanted ..." When I've put the biology in her hands, just because she knew someone ").

She concluded with the observation that if things were so, then he would have come to psychotherapy just to talk about childhood. We can interpret as an invitation to repair the substance from which it is made, as a prerequisite for any attempt to be treated psychotherapeutically. (She is in an inaccessibility: the state of evil is too great that it is not convinced by persuasion and relaxation techniques (to say like, "I'm ready to come tomorrow and I tell you everything that happened in my childhood!").

D. Psychological Examination and Psychiatric Perspective:

Sensations - Sensory hyper vigilance and hypersensitivity, as evidenced by the patient's speech, especially auditory hypersensitivity due to irritability caused by depression.

Thinking / perception - meditations, the patient presents a complex picture, built on the background of a hypochondria, hypersensitivity, interpretation, prevalent ideas, running on the prevailing plane to delusions

Impact - The patient reports feelings of weight, pressure, intense agitation, fear, inner tingling, at the same time, however, her speech is flat, mechanically disturbed, in a rather tedious, equal tone, with no obvious affective modulation.

Behavioral plan - passive, avoidant, isolation behavior of the patient's speech is reflected in both his socio-professional relations and psychiatric treatment. At the same time, on the aggressive face we notice the compulsion to diet and the behavior of „doctor shopping", the constant search for diagnostics and new substances to inject them in order to improve an obvious psychological condition (cognition and behavior in different plans).

1.1. Psychological Tests Applied

The patient was clinically evaluated on the basis of several types of psychological tests, namely: the Szondi pulse test, the CIQ Personality Inventory, the Depression Clinical Scale, the Lusher Color Test- the quick version.

2. THE SZONDI TEST

It is a deep psychodynamic test that reveals the unconscious processes of the destinies of the pulsations and the Ego. The test points out: the unconscious aspirations of the individual; The unconscious position of the Ego over the pulsating danger; The dialectic between the pulses and the Ego (reveals the unconscious processes of the pulsating destinies and the self).

The patient is asked to choose, in several halves, several photos of faces of people with different mental illnesses, in the order of personal preference (most sympathetic or most unpopular).

It is important to note that in the four applications of the test, the patient did not make consistent choices, which could be an indicator of a poorly developed, lean, subject to pulsating assault. (Layout: energy level: low, sad, unhappy, not feeling good inside with her, afraid, lack of libido).

The final score of patient M is as follows:

Sch		**P**		**S**		**C**	
p	k	hy	e	s	h	m	d
-	0	0	0	-	+	+	+/-
-	-	-!	0	+	+	+!	0
0	-	-	+	+	-	+	+/-
+	0	-	+/-	-	+	+	-
p_0	k_2	hy_1	e_3	$\$_0$	h_0	m_0	d_3

The identified pulse pattern is the following, with the following features:

• astheno-depressant excitability with hysteroid passivity, dependency • Curative depression • Affective addiction that ends with post-paroxysmal depression • Ego estranged with myself • Timid searches • Possible phobias	e3 d3 k2 hy1
• Who actively opposes her own immaturity (Pseudo-mature structure)	h0 p0 s0 m0

In foreground, there are tendencies such as: asthenia-excitability, punctual discharges through uncontrolled nerves, a mixture of depression and asthenia with twitching (accusations of aggression and exaggerated

nervousness, sensitivity to rejection, catastrophic vision concerning illness, high inner agitation + permanent fear) between two extremes, from staying "wide in bed" without being able to rise (catatonic) to fury crisis outbreak (which can lead to suicide , totally non-contentious gestures), an apathetic-aboulia dimension of social withdrawal (not to get out of bed and not take care of personal hygiene - social isolation).

In the present accumulation plan, hy1 indicates the tendency towards hysteric personality, a surprising aspect in her personality structure, which is consistent with the „doctor shopping" behavior, with moments of acting-out that take very short periods of time, in which the Self gives up fighting, and stops resisting the pulsating assault. (The chat about the neural mediators makes the patient avoidant and so, she does not connect to what really bothers her; she tries all the rational explanations only to have no insight).

The structure h0, s0, p0, m0 denotes an immature, or more fairly non-mature personality, a hiding structure that actively opposes its own maturity.

P0 takes into account the sensitivity to rejection and the interpretation of the inner world of the patient (sensitivity to rejection, high inner agitation and permanent fear), as well as to the sensory hypersensitivity. (she cannot stand the noise, she sleeps with ear plugs, and any noise is heard in the apartment irritates her till she breaks down)

The psychic structure of the patient is characterized by asthenic-excitability, passivity and subordination (D3), with a coarse depression (Ego-constriction), which causes depression to be inhibited by noradrenergic mechanisms (see this correlated tendency with the prevalence of the size of the non-transmitters) - the fact that the patient itself brings in several times the "decrease of noradrenaline" (all the discussion on the neural mediator causes the patient to flee and not connect to what really bothers her).

Even if we can assume that she read the booklets of the drugs she takes as a treatment and probably from other sources, she seems to show an effort to break / annihilate (or at least undersize by compaction) the unconscious and pre-conscious levels of the psyche of the patient in the sense-somatic-physiological direction, direct projection in the level of conscious-behavioral concerns, and with an effective shunt of affective dimension.

Also, the patient has the characteristics of apathy, lack of any drive or pulsations, which take into account the absence of motivation. Medically speaking, there are low levels of noradrenaline, or noradrenergic depression. Sadness, anxiety:

- Pessimistic attitude
- Slack of interest and pleasure
- Low energy and fatigue
- Insomnia
- Concentration difficulties and decision-making

Affectively, it falls on the magnitude of affective dependence, which ends with depression after discharge . The Szondi pulsation theory indicates presence as a precondition for a high excitability constitution that is paroxysmal discharged, followed by the depressive episode.

As a pulsating dynamics, patient M is marked by a continuous struggle with pleasure, to the precondition of death by pleasure (like a muzzle that pushes the pedal to exhaustion, or to the suffocation feeling - breathing, breathing, breathing). (Looking for "drugs" to make her happy: sweets, sausages, cigarettes).

The patient exhibits an asthenia-excitability with elements of hysteria, sensitization denoted by the need to convey material psychic processes: drugs, neurotransmitters, their effects on the body (immunity, polyarthritis, vitamin deficiencies, asthma, pain).

She needs to be able to „touch" the illness, for she cannot reach the psyche, which is why she pushes all the searches into the somatic area). She has major ideas centered on her functioning, her psyche and neurotransmitters.

It is also evidenced by the repeated somatization, ever since childhood, of emotional and psychological neo-general in general. At the same time, the patient has nothing, the libido is low, the pulses manifest to the soma, although he has no somatically diagnosable disease. (Unhappy, she does not feel good inside her, she is afraid, lack of libido.

The Szondi test also shows signs of schizophrenia, but it is in the phase of major inhibition. (She does not have delusions and delusional ideas) Also, the indicators are tending to anxious-depressive type, with dissatisfaction with parents.

The test confirms hypersensitivity and sensitivity with some obsessive-compulsive, schizotypal features. There is a major depressive disorder with a history of recurrent depressive disorder.

In interpersonal relationships, she seeks pleasure only for her, not for her partner, anything she can keep for herself. She rationalizes a lot and does not come into psychological contact with herself, she talks a lot about drugs and her body, it seems to be a mechanical operation, there is no psychological affection. (All the reflex on the neural mediators makes the patient run away and not connect to what really bothers her; she goes to all rational explanations only to have no insight).

She only talks about the relationship with her mother and identifying with her with fixation on mother and mother's disease. (It's in identification with my mother (the first time I thought I had my mother's polyarthritis) The patient seems to be stuck in the process of defining a corporeal mine, without succeeding in adding to it a psychic "me" that remains intangible (cannot be grasped, touched in its own way).

3. CAQ. PERSONALITY INVESTIGATION

The score obtained by the patient on the dominant dimension E (score 9 of 10) in the CAQ correlates with the intransigent Self with the Szondi Self Test and denotes: aggressiveness, competitiveness, direct attitude in relationships with others (say what he thinks without filtering) Waiting for the world to behave according to its own way of being, stubbornness that masks the feelings of inferiority, the ability to expose its hostile feelings that can burst even violently and unexpectedly (co-produces with the E3 factor in Szondi).

On the sensitivity dimension, the obtained score correlates with sensory hypersensitivity, irritability (low sensory threshold), but also with addiction, insecurity (the patient wants and seeks over-protection).

The N 10 score of perspicacity denotes the desire to learn exact sciences so that she can know what is happening with the greatest accuracy. Q2 factor with score of 8 shows self-sufficiency, preference to be alone, to work independently. This factor strongly correlates negatively with extravasation in other tests.

Score 9 on Q4 indicates the level of internal tension, it is an indicator of the anxiety pattern, but also an indicator of frustration. (High inner agitation + permanent fear).

The conclusion we draw from is that M's inner struggle is to resist the pulsating assault, from which the fascination developed for intracellular biochemical processes.

4. CLINICAL SCALE OF DEPRESSION

The test is composed of 7 depression scales, which the patient's relative high scores on all scales are:

D1 – Hypochondriac depression	score 10
D2 – Suicidal depression	score 8
D3 – Depression of agitation	score 8
D4 – Anxiety depression	score 8
D5 – Low energy	score 8
D6 – Blame and resentment	score 8
D7 – Boredom and passivity	score 8

Depression scales describe the patient's structure. In case of patient M, there is a greater attachment in the thinking than in the affections, as observed in its fixation on the neurotransmitters, namely the adherence to a fixed theme and a predominant idea of the prevalence. (the discussion on the neurons modulation makes the patient deflect and not connect to what really bothers her, tries rational explanations only to have no insight).

On the scale of psychopathy, which distinguishes between recurrent depressive disorder (DSM Axis I) and depressive structure (DSM Axis II, Personality Disorder), the score is 2, which indicates that the patient is not a psychopath, so we are on Axis I of depressive disorders. (The patient is neurotic (he is not psychotic because he lacks delusional ideas and hallucinations).

The other scores are for paranoia 10, for schizophrenia 9 and for obsessional 9. The scores for paranoia and schizophrenia are disease indicators, while the obsessive score denotes the tendency to control one's own being, as observed in other tests.

Patient M works in a prevalent to delusional registry.

From a psychological point of view, the features are: sensitivity, sensitivity, interpretation of phenomena in the inner world; from psychiatric perspective, psychotic phenomena occurs, and it is highlighting this outfall at the surface of the hallucinatory formation mechanisms, as described by Kaplan, as somatic disturbances on nerve fibers. We can even assume that the tested patient could be somewhat psychotic, but precise indications of this aspect could not be observed, in the absence of interviewing the defendants.

She could be a psychotic patient because she has no control and no longer realizes what's going on. She does not struggle at all but seeks only a solution in her psychosis, only that the psychotic level is low, and she says she has no delusional hallucinations and ideas but has prevalence. The patient no longer bears the noise, he sleeps with ear plugs, and any noise is heard in the apartment it's irritating her. What he says and feels does not seem to be hallucinations or illusions, but it seems to be more irritable and lower sensory thresholds (sensation on nerve teats that can lead to hallucinations).

5. LUSHER TEST

The color test, Lusher, is also applied in its short version, which is a quick indicator of the areas of suffering of the personality of the person under test, on the basis of which their prognoses or validations can be made.

There have been two applications with the following results:

Protocol 1:

BLACK, BROWN, GREY, YELLOW, GREEN, PURPLE, BLUE, ORANGE

Protocol 2:

BLACK, BLUE, BLUE, BLACK, GREEN, PURPLE, YELLOW, ORANGE

The interpretation of patient results M in the Lusher test leads to the following conclusions:

Desirable goals / behavior dictated by the desired goals of the patient: it aims at idealistic but illusory goals at the same time. This way to make choices is confirmed by the patient's option to pursue a masters of medical studies whose requirements exceed her level of professional training and adaptability and coping skills, denoting a low degree of probation of reality in self-evaluative processes.

It manifests itself with dissatisfaction, creating practical circumstances in which to find justifications for this state. (Dissatisfied with the medication)

It despises life with a disgusting attitude towards itself and wants to recover - this attitude is indicated by the choice of black and brown color. The patient wants to free himself from conflict and be given the chance to recover (the couple brown and gray). She first wants to solve the problem of the present (agitation) and then talk about childhood.

The existing situation / behavior dictated by the existing situation, according to the interpretations of the Lusher test scores, is characterized as follows:

The gray-yellow pair - the failure achieve her goals ("I did not get in high school"), the inability to decide even in minor election situations without important stakes.

The retained features are as follows:

She feels that she receives less than she deserves, feels there is no one to trust. The repression of emotions makes her slightly sensitive to criticism. (correlated with P0 from Szondi). Sexual Neurosis.

The patient's anxiety can be characterized as: dominated by a considerable amount of emotional pain gained from the relationships she has had, unable to establish connections with other people (overwhelmingly egocentric)

Imbalance, lack of help, irritability (blue/red pair); Disappointment that leads to agitation. (Unhappy, she does not feel comfortable with what she represents, constant fear, lack of libido).

She has doubts concerning other people, she considers herself a victim who has been maltreated and confuses this internal reality with the external reality (the pair of yellow-red colors)

The consequences of stress: intolerance, weakness, she thinks she has been sacrificed and insistently insists on giving her own way in life (black-red).

E. The Psychodynamic Perspective

The agitation that the patient claims is a symptom of major depression, which confirms the psychiatric diagnosis. Characteristic for deep depression are also the strange dreams that interrupt sleep, as well as rumination and compulsive eating, especially sweets, at inappropriate hours with the purpose to relax.(Looking for "pleasure drugs": sweets, sausages, cigarettes) and sleep problems (sleeping hard, waking up a few times a night, restless sleep, dreaming strange things, insomnia).

Thus regressive oral fixation occurs, with fixation at a pre-Oedipal stage (sucking calms the baby), as well as a fixation in the area of magical thinking, also characteristic of the early stages of the development of the Ego. The patient is in a constant quest for the magic cure, dust, or magical droplets, the perfect medicine, which in one administration can fix everything. (She brings all kinds of rational explanations only to have no insight). For this reason resistance to antidepressant treatment occurs as well as the repeated request to discontinue administration, claiming that the treatment will take too long, and would have undesirable side effects (discontent with medication (it does not feel like it did in the beginning, blame the pills for the way she feels). The drug that is not perfect, enchanted, is poisonous [2].

The long-term treatment goes out of the "good magic" category, entering the "evil magic" category, becoming the concrete evidence of the mental illness she is looking for, and she puts it at the expense of substances, thereby denying it.

It is the denial of mental illness by a fragile Ego, who is also seeking confirmation through illness. (dissatisfied with the medication (she does not feel like she felt at the beginning, blame the pills for the states she owns).

It can be noted the narcissistic and hysteria form structure, characteristic of the first stages of psychological development, by the need to be the focus of the husband, mother, and doctors. (She has a younger sister she's jealous of (since she appeared her parents have neglected her; about her sister they speak with pride, but they laugh at her, they helped her younger sister to go to Law school but they did not let her apply for college, she had to stay in hospitals and now she cannot take the mind of the smells she felt there = discomfort.)

The narcissistic structure is also proven by the search for the incurable disease - schizophrenia, cancer - the only illness that this patient with a fragile and inflationary Ego might suffer). She is afraid of the psychotic plane (she asks if she suffer from schizophrenia because at some point she felt the urge to clutter children's throats when they were making noise).

It is another confirmation of a negated immaturity and vulnerability with which she continues to struggle. In the same vein, we can also notice the "jealousy" manifested in the relationship with the mother whom she steal the disease she suffer from (polyarthritis) in order to keep herself in the spotlight, and to preserve her pattern of

functioning in interpersonal relationships, especially In the relationship with the mother. (It's in the identification with the mother (the first time I thought I had polyarthritis like my mother).

She was forced to change roles when she brought her mother to the doctor, in a hysterical manner the patient feels the symptoms of the mother's disease (joint pain) and takes a treatment to get rid of them (glucocorticoids for asthma and vitamin D2 For strengthening the bones), unconsciously redefining her position as a child in the relationship with the mother, keeping her in the center of maternal attention (both the real mother and the inner mother). This diminishes the importance (disease) of others in her system of interpersonal relations and internal object relations.

The sense of helplessness is consistent with the characteristic immaturity and is still a symptom that supports the diagnosis of major depression. (Immaturity (immature- envious of children, envious of the co-worker who did what she could not)

The patient claims infirmity as a permanent, characteristic condition: she cannot learn, cannot get out of bed, cannot do useful things, feels like a disability, cannot get out of the house, etc., matching the oral fixation (she cannot focus or learn for exams).

Based on these issues appears the fear of rejection in social relations, fear that makes her want to "escapes from presentation" and social isolation, in an infantile manner, characteristic of the stage of psychological development of the patient. An apathy-aboulia dimension of social withdrawal (to not get out of bed and take care of personal hygiene - social isolation).

She feels inferior compared to other people (just as a child feels slightly inferior to the adults around him). She cannot even stand the thought of being in front of a crowd of masters colleagues whom she consider more trained than she is.

On the sensibility plan (especially the auditory), stands out the patient's hypochondria (the aspects of depression and hypochondria; depressive personality disorder and hypochondria) which she exhibits in a cognitive and behavioral way through Dr. Shopping's(the appearance of hallucinations and the risk of fixation in this behavior (doctor shopping) and the "explanations" related to the action of some substances that she gives to the different symptoms of suffering, but also as a defense of the child's position in the fantasy and behavioral plan)

The compulsions and obsessions, which characterize excessive attention to one's own person, come as defenses mechanisms in addition to avoidance and isolation behaviors, to support the fragility of the Ego and the fear of death (death of pleasure or sickness) and rejection (escape from presentation, inability to leave the house, etc.). The example of the mumble that dies of pleasure joins the other mechanisms of rationalization, intellectualization, which indicate the denial of her immaturity and associated incapacity. Her ego is very fragile, the psychological development is marked by oral, pre-Oedipal fixations, and the interest in medicine (see the master's degree), for rational explanations given to the symptoms she suffers, is an attempt to compensate for this characteristic immaturity [3].

The patient has difficulties in raising her imbalances in the psychological plan, her body choosing recurrent somatization and cognitive intellectualization (the concern for the mechanisms of action of substances at cellular level). She has major ideas centered on her functioning, her psyche and neurotransmitters. In addition to depression is added a facet of obsession a compulsion, anxiety and bulimic pulses, all of which prevent the manifestation of psychiatric acceptance and awareness.

On the sensibility base, she seeks the most appropriate disease, which, in a narcissistic manner, can only be the worst, and in the hysterical manner it is the one her mother suffer from, or of those close to whom she can not pay attention (identifying with her mother).

She is strongly centered on herself and especially on her own body, an obsessive-compulsive disorder. She can do nothing for others, only for herself. Including the decrease of libido is claimed in the context of complaints about

the inability to meet the others needs - in this case, the likely spouse, and the search for pleasure respectively of her own pleasure [4].

Denial along with awareness of the disease is accomplished by fusion-primitive operation in the projective mainframe. The genetic background, body cells, mom and dad, and especially the mother, are responsible for her states of suffering, not herself. Denying any assumption of the disease makes it difficult to work with this patient. For her there is no psychological cause, nor does she ask herself, her own illness, everything is at the level of neurotransmitters, substances and cells in the nervous system.(all the talk about the neural mediators makes the patient deflect and not connect to what really bothers her, goes into all sorts of rational explanations only to have no insight) [3].

She uses a seemingly psychoanalytic "heard" speech from the various doctors she visited or picked up from various books she may have read in order to give substance to the projections of responsibility the disease gave over parents (mother). (Relationships with parents and brothers: she has a younger sister she is jealous of (since she appeared her parents have neglected her; about her sister they speak with pride, but they laugh at her, they helped her younger sister to go to Law school but they did not let her apply for college, she had to stay in hospitals and now she can not take the mind of the smells she felt there = discomfort.)

On the relationship with her father we observe self-pity, self-stimulation, but also a present exhibitionist behavior, a hysteroidal bill. From the patient's speech it appears that her father is the one who opposed her to go to college (we can suspect the existence of an awareness or perhaps only parental preconscious intuitions of the psychic, mental development deficits of the daughter during her childhood). Thus, there is another guilty person who is responsible for her present misery and suffering, presently punishing her husband by asking him to accompany her to the gynecologist. On the sexuality side, she behaves frustratingly for the man who remains in the waiting room and for whom she remains so inaccessible [5].

In addition, the decrease in libido appears as another way of rejecting the sexual aspect of the conjugal relationship, which, by softening its procreator content, turns it into an anaclitic relationship - the husband sustains (the massage salon, and on it accepting As it is: depressed, inactive, and taking things easily). She take from her husband everything she can take without giving anything back. The lack of support from the father is offset by the support she receives or feels she receives from her husband.

It is possible that the patient's functioning is a hedgehog, a modeling of the mother's fears, which, by internalizing the maternal subject, takes them as behavior towards herself - going to the doctor remains the main concern of the patient, as was the mother's preoccupation during childhood. (in the identification with her mother (the first time I thought I had polyarthritis as my mother)

The patient herself understands and says that her perception was that the only maternal affection she felt from her mother in childhood was the fact that her mother was taking her to all sorts of doctors. She is currently addressing this request to her husband accompanying her when she goes to a doctor. The result of the paternal affection shown by her father through guidance to a profession seems to have been negative from the patient's perspective, in the sense that, following her father's counseling to become a nurse, she was traumatized.

We have the evidence of traumatized sexuality, the memory of the patient being one in which she suffocates (breathe, breathe, breathe) and is experiencing sexual assault (the urethral probes in the male patients she saw and probably learned how they are mount when she was still a child, as the patient says). She says that, because of paternal guidance, she has suffered as a child, at the age of 14, in a hospital where she felt horror.

In this context, the sister appears in the story, whose birth seems to have triggered in the patient the struggle for the place in the center of the attention of the parents, a struggle that continues even today, in the hysteroid manner we have already presented. (She has a younger sister she's jealous of (since she first appeared, her parents neglected her, about her sister speak with pride, but make fun of her).

There is, however, in the patient's speech a pre-conscious plan, in which there is a certain awareness of possible alternatives to the perceptual picture of her childhood, but also of the present. She says at some point it may not be the way her parents tell her, maybe she was not a bad girl who wanted to harm her sister, maybe she has good parts too.

Unconsciously, however, this apparent awareness comes in the support of denying self-responsibility and own illness, putting it pro-actively to parents - perhaps she is not the bad one, maybe her mother, father and sister are the bad ones, perhaps they, with their poor genetic material are responsible for the condition of the patient and for all past and present suffering.

The patient is thus disturbed by the idea of defective filiations, the endogenous disease, which also induces the state of complete impotence (for the filiations cannot be changed) and the hypochondria (something must be changed at the microcellular level by the addition of substances because there is a native deficiency), the exaggerated concern for substances, drugs, which must compensate for what is lacking in the genetic material. She has major ideas centered on her functioning, her psyche and neurotransmitters [6].

It is very likely that these insights have even a real basis, and constitutional factors may even play an important role in determining its psychosomatic-physiological state, and the manifestation of these conscious ideas is the result of these "data".

On this basis there is a lack of meaning and implicit hope, also a characteristic feeling of major depression. (Major depressive episode with psychotic phenomena)

The neurotransmitters dimension that is so pregnant in this patient is a libidinal fixation of prevalent psychotic intensity. The patient seems to be offered as a case study, in the exhibitionistic manner characteristic of the hysterical personality structures. She has major ideas centered on her functioning, her psyche and neurotransmitters [7].

The patient continues to treat himself as a small child, "nourishes" himself literally and figuratively, in a manner that will help her deny her own immaturity. Envy the children; envy the colleague who did what she did not. Responsible for all her suffering are the parents, who have disappointed her both constitutionally (genetic material has to be improved with the addition of drugs) as well as social (see the student's episode that surpassed her because the student knew someone (Dependence and immaturity (imitate-envious on children, envious of the co-worker who succeeded what she did not) - while her family, both current and home, could not afford the right social relations to be happy), and put her in a position to struggle to repair something that cannot be repaired (hence the lack of sense, the lack of hope, the sense of helplessness that characterizes the depressed state of the patient).

It seems to be in constant search for information to confirm her position as a victim. However, the incompetence of cognitive synthesis is noticed as proof of the patient's mental disorder and mental development. She remains extremely attentive to herself, being narcissistically fixed to herself, attention that slips quickly to the idea of illness, whose confirmation she seeks in her body to be able to deny her mentally.

Her hypochondria comes on an extremely fragile and vulnerable Ego even in the simplest social situations (isolation, the refusal to get out of bed, homelessness, dropping out of the teacher's post, running away from the presentation), Ego who always have to prove he is strong. (hypochondria depression: immature-dependent personality structure and attachment problems with mother) [8].

("A 40-year-old woman is a strong woman" - this affirmation itself is a denial of the affective and cognitive immaturity of the patient).

Professionally, the patient chooses to be a gymnasium teacher, and stays at this level, prepubescen, without finding the resources to advance in the career and envious on other colleagues (former students), feeling overtaken by them and deprived by her own merits. Merits that she does not find the energy she needs to harness herself in her own interest, or perhaps she does not have anything to develop, given the degree of immaturity she strives to hide from herself and others, but above all by herself.

Her personality also features a hysterical facet on a depressing, anxious background that develops obsessive-compulsive behaviors and phobias that appear in socialization and as a genetic predisposition in the hereditary sense, so in different planes, having as a trigger many past or potential losses - the loss of a career, the chance to study, a successful business, the service, the ability to excel in the master, to be at the center of attention (at the birth of the sister), innocence (at age 14), etc.

The patient's hypochondria is sustained and reinforced by the behavior of the mother who went a long way with her to the doctor, and denotes her somatic fragility. At the same time, it can be a mantle of the mother's fears, confirmed by repeated infant somatizations, which have strengthened the mechanism (Hypochondria: the immature-dependent personality structure and attachment problems with mother).

The patient's hypersensitivity is the fund that nourishes "the search" for the serious illness she feels she suffers from, investigations, medical consultations and analyzes, etc., but also the force with which she projects, out of fear of illness: it's not from me, it's from my mother. Triggering may be repeated somatization, perhaps even when she was a nurse and was in direct contact with the disease, but also a possible constitutional fragility.

In counter transfer, the therapist notices its own aggressive resonance in the patient, that the voice gets passive and aggressive accents, reflecting the way the patient works, and the underlying and well-inhibited irritability of the patient [9].

She also notes that she cannot interpret the patient's discourse, but only on her own discourse, which may be the indication of the primitive narcissistic functioning of the patient, making it difficult to exchange projective identifications that imply the ability of the Ego to interact with another.

Also, the mechanism of pushing all the explanations and causes to the somatic level makes it difficult to work in the psychic plane, the therapist ending the meeting with the thought: "I do not know what to start with! What do I do about it first? ". As an indicator of the precocious difficulty of this patient's psychotherapy.

6. CONCLUSIONS

Personality Structure: Patient M. presents a predominantly narcissistic personality structure with passive-aggressive elements with multiple history of somatization, decompensated in major depression with prevalence, sensitivity to rejection, interpretation of the inner world (fixation Pulsatile on a hypo concentric body), irritability, sensory auditory hypersensitivity. Manifestations in the bulimic compulsive registry (binge eating).

Psychodynamic: The patient has a marked desire to seek pleasure accompanied by guiltiness. (Desire accompanied by culpability) Defense mechanisms: rationalization and intellectualization.

Evolving risks: possibility of decompensation in the psychosomatic registry (asthma, coronary diseases), risk of psychotic decompensation (the occurrence of hallucinations), risk of excitable explosive manifestations, risk of fixation of the hysteroid structure ("picture type") - tendency present by the behavior of Doctor Shopping. (RISC - the occurrence of hallucinations and the risk of fixation in this behavior (doctor shopping) [10].

Defense mechanisms: rationalization and intellectualization. Negative prognostic factors: hereditary load doubled by translation of defective role models, endogenous appearance of depression.

Funding: This study received no specific financial support.
Competing Interests: The authors declare that they have no competing interests.
Contributors/Acknowledgement: All authors contributed equally to the conception and design of the study.

REFERENCES

[1] V. A. Coenen, T. E. Schlaepfer, B. Maedler, and J. Panksepp, "Cross-species affective functions of the medial forebrain bundle—Implications for the treatment of affective pain and depression in humans," *Neuroscience & Biobehavioral Reviews*, vol. 35, pp. 1971-1981, 2011. *View at Google Scholar | View at Publisher*

[2] G. Foussias and G. Remington, "Negative symptoms in schizophrenia: Avolition and Occam's razor," *Schizophrenia Bulletin*, vol. 36, pp. 359-369, 2010.

[3] S. Jauhar, P. J. McKenna, J. Radua, E. Fung, R. Salvador, and K. R. Laws, "Cognitive-behavioural therapy for the symptoms of schizophrenia: Systematic review and meta-analysis with examination of potential bias," *British Journal of Psychiatry*, vol. 204, pp. 20-29, 2014. *View at Google Scholar | View at Publisher*

[4] D. Malaspina, M. J. Owen, S. Heckers, R. Tandon, J. Bustillo, S. Schultz, and J. Van Os, "Schizoaffective disorder in the DSM-5," *Schizophrenia Research*, vol. 150, pp. 21-25, 2013. *View at Google Scholar*

[5] Y. Levkovitz, S. Mendlovich, S. Riwkes, Y. Braw, H. Levkovitch-Verbin, G. Gal, and S. Kron, "A double-blind, randomized study of minocycline for the treatment of negative and cognitive symptoms in early-phase schizophrenia," *Journal of Clinical Psychiatry*, vol. 71, p. 138, 2010. *View at Google Scholar*

[6] L. L. Judd, P. J. Schettler, H. Akiskal, W. Coryell, J. Fawcett, J. G. Fiedorowicz, and M. B. Keller, "Prevalence and clinical significance of subsyndromal manic symptoms, including irritability and psychomotor agitation, during bipolar major depressive episodes," *Journal of Affective Disorders*, vol. 138, pp. 440-448, 2012. *View at Google Scholar | View at Publisher*

[7] M. S. Ritsner, A. Gibel, T. Shleifer, I. Boguslavsky, A. Zayed, R. Maayan, and V. Lerner, "Pregnenolone and dehydroepiandrosterone as an adjunctive treatment in schizophrenia and schizoaffective disorder: An 8-week, double-blind, randomized, controlled, 2-center, parallel-group trial," *Journal of Clinical Psychiatry*, vol. 71, pp. 1351-1362, 2010. *View at Google Scholar | View at Publisher*

[8] M. M. Sidor and G. M. MacQueen, "Antidepressants for the acute treatment of bipolar depression: A systematic review and meta-analysis," 2011.

[9] S. P. Singh, V. Singh, N. Kar, and K. Chan, "Efficacy of antidepressants in treating the negative symptoms of chronic schizophrenia: Meta-analysis," *British Journal of Psychiatry*, vol. 197, pp. 174-179, 2010. *View at Google Scholar | View at Publisher*

[10] M. Jäger, S. Haack, T. Becker, and K. Frasch, "Schizoaffective disorder–an ongoing challenge for psychiatric nosology," *European Psychiatry*, vol. 26, pp. 159-165, 2011. *View at Google Scholar | View at Publisher*