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DEPRESSION AND SUICIDE IN WOMEN CHARACTERS OF THE EARLY 20TH CENTURY

Ionuț I. Jeican¹, Doina C.M. Cozman²

Abstract:
Literature is the art of words that describe life. In the case of human life, suffering plays a special role, and literature scrutinized man’s suffering and described it in its various forms. This article presents three cases—literary characters whose psychopathology we interpreted on the basis of their literary text: Tincuța—from the novel “Tânase Scățiu” by Duiliu Zamfirescu, Ana—from the novel “Ion” by Liviu Rebreanu and Margareta—from the play “Gaitele” [Jays] by Alexander Kirițescu.

Keywords: anxiety, depression, suicide, Zamfirescu, Rebreanu, Kirițescu

Even though women did not play a major role in the political and social events of early 20th Century Romania, they endured a lot of pain by them. We present these sufferings as mirrored by the Romanian literature of the time and interpret them from a medical point of view.

We analyzed the psychopathology of three characters: Tincuța—from the novel Tanase Scățiu by Duiliu Zamfirescu, Ana—from the novel Ion by Liviu Rebreanu, and Margareta—from the play Gaitele [Jays] by Alexandru Kirițescu. From the literary text we collected patient information and data for the mental state examination, and based on the findings we established the most probable diagnosis.

Tincuța—a bridge between the landlord and the steward

From an esthetic viewpoint, the work of Duiliu Zamfirescu (1858-1922) is marked by classical orientation (1) and classical balance (2). His most important achievement is his contribution to the development of the Romanian novel. Tanase Scățiu (1907) is the second volume of the cycle Comanesteanu’s Novel, the first serial novel in Romanian literature (3).

His ideological development under the Junimea trend guides Zamfirescu toward the social novel, the conflict that opposes the old Romanian nobility (boyars represented by Dinu Murgulet, a lover of the land and of the peasants) to the new rural bourgeoisie (represented by Tanase Scățiu, the prototype of the upstart steward, who have nothing to do with tradition and land ties and whose only purpose in life is to become rich by exploiting the peasants; this social category will hold a considerable influence in the late 19th Century Romanian political scene) (3).

The action of the novel takes place in Walachia (south of modern Romania). Tincuța, boyar Dinu Murgulet’s daughter, marries, at her parents’ will, Tanase Scățiu, and thus has to abandon her dream of love for Mihai. She gets trapped in an unhappy marriage: “From the very first day [...] Tincuța’s life was a constant fight against misfortunes”.

Scățiu’s character is outlined both by direct description by the author (“twisted nature”, “a miser and a bragger”, “tyrant of the house”) and indirectly—by dialogues or actions: (to the horse driver): “Get off, asshole [...] for the last twenty years you keep going but never leave. If you could just go to hell! [...] he whipped the horses and took off leaving the coachman in the mud”; “The master strikes like blind and the servant defends his head with both hands” (to his daughter).

“As we can see, Scățiu has a despicable nature, rude and vulgar, a man dominated by bouts of rage. He offends and diminishes his wife: “Aww! The stupid wife I’ve got” [...]. Tincuța casts him a glance. She’s all flushed with anger [...] tears have come to her eyes. “You’re all a bunch of nutters, you and him, and all your kind [...]”

“You want to end my life before it’s finished” “Oh please, all of you are the devil’s work, you don’t perish easily”

Frustrated emotionally, hurt by the rift between dream and reality, Tincuța lives in regret of her old love dream for Mihai. During the years of the harsh and humiliating existence with Scățiu, Tincuța develops a depressive disorder, with elements of anxiety: “Wherever she turned her mind she saw only deep desolation: she loathed her husband, she revolted against the society that could tolerate him, against God who kept him alive; her father had become selfish, childish, obsessed solely by his land [...] beside her, everything was painful and bleak” (depressive component): “For some time already, I have started to fear something unknown” (anxiety component).

Tincuța had had medical consultation and received treatment, which she discontinued later: “The doctors believe I have a nerve disease [...] They gave me
me all kind of drugs, which made me sleep like a stone. I gave them up”. Under the circumstances, the character’s disease progresses toward major depression: “The life with her husband seemed a monstrosity”, “The smallest anything made her cry”, “No one understood her”, She couldn’t sleep and lost weight”. She felt abandoned by the whole world, drained of strength, without hope”. The constant conflict between the landlord and Scățiu amplifies Tincuta’s mental strain: “Please father... What can I do?... He chases me away, you chase me away... I am so miserable!”.

![Image](image.png)

**Figure 1. Tincuța (Cristina Nășuță) – a screen shot from the film after the novel „Tânase Scățiu”, directed by D. Pîta, 1976**

The depressive patient’s perception of the world and life is vividly depicted by the writer: “She gave him the letter, which he threw into the stove. They were both looking at the burning paper, which crumpled and revealed the black letters on the grey background. Tincuta nodded her head. “This is how all that is human perishes [...] The idea of death had budded in her mind for a while now. She felt sick and hoped to die soon”.

From a psychological point of view, the events are simplified, while from the point of view of the epic construct they are hastened, precipitated (3). Tincuta probably dies from conditions secondary to depression, which are not described. “Her tormented life dwindled away slowly, little by little, leaving only the mark of the very last moment of consciousness, that she stopped hurting. She died with the clear thought of the happiness to be no more”.

In the end the narrator punishes the main character. The peasants rise against Scățiu and after getting justice from the state institutions they attack him and kill him in a scene that forecasts the peasants’ uprising from the novel Răscoala [Uprise] by Liviu Rebreanu: “In one second they broke him to pieces [...] At the inquest his face was a mask of pain and tears. His eyes swollen with rage fell on the mocking belly and he began to punch her with his fists in the head, the ribs, the belly, in a quick frenzy, panting and roaring: You slut!... slut!... I’ll kill you now!... Tramp!... Glanetșu’s son... is that what you wanted? Here then, dirty whore! [...] His eyes swollen with rage fell on the mocking belly and he started kicking her with his feet, yelping with satisfaction, as if every kick took a burden off his chest. Ana’s crossed arms tried instinctively to shield the fierce blows that threatened the fruit of her sin [...] Vasile Baciu dragged her inside, almost unconscious, closed the door and continued the beating fervently”. The next day Vasile “flung himself on Ana again, though she was covered in bruises, and beat her till the neighbors rescued her from his hands [...] From then on no day passed without beating her until he got tired”.

Sent by her father to discuss marriage arrangements with Ion, “Ana set off to Glanetșu’s house with her heart heavy, her body mortified. Her mind was drained like a dry sponge. No hope, no faith. She walked without knowing, like a chased away dog. Her pace was quickened only by the terror of the old man’s strange gaze, in which her death seemed to be floating [...] and found herself in Glenetaș’s house without realizing whether she had met anyone on her way or whether outside was sunshine or rain [...]. The girl sat on the trunk uninvited, as her knees were trembling like jelly.” By this time the character already suffers of depressive disturbance. The etiology of this phase of depression includes the cruelty of the father for his daughter. Ana, childish and candid, still felt love for Ion: “Ana could only think of him, forgetting all shame, beatings and suffering”, despite his contemptuous attitude (“I loathe Ana more than I would a witch”). Ana behaves like a victim fascinated by the prey animal that caught her.

The wedding gives Ana the illusion of happiness for a brief moment: she floats “on a big happy cloud and feels redeemed for all the pain”. When during the dancing Ion embraces Florica passionately, Ana feels that “her literature (2), depicts the atmosphere of the Transylvanian village in the beginning of the 20th century.

The novel architecture unfolds on two planes: the peasants and the village intellectuals. The social layers realistically reflect the social and economical conditions of the times.

Ion of the Glanetaș family, the main character, is torn between two desires – “the voice of the land” and “the voice of love”. A stark poor lad, “whom his parents gave only his soul”, seduces Ana, the daughter of the rich peasant Vasile Baciu, making her pregnant in order to force his future father-in-law to give him some land.

After the sexual intercourse with Ion, Ana develops a feeling of anxiety: “Since that night she had been living in fear [...] Every minute she was waiting for her sin to be revealed and this wait was even more painful than the thought of the error itself”.

When Ana can no longer hide her pregnant body and Vasile Baciu finds out who the father is, he punishes Ana by repeatedly beating her, which triggers in Ana anxiety disturbances: “The terror welled up in her so fierce that she started crying in despair with a thin voice: Don’t kill me, dad, don’t kill me, don’t kill me! [...] and her limp arms crossed over in defense over her round belly [...] [Vasile Baciu] thrust his hand into her hair and with a brutal wrench brought her down to the ground. Then he began to punch her with his fists in the head, the ribs, the belly, in a quick frenzy, panting and roaring: You slut!... slut!... I’ll kill you now!... Tramp!... Glanetșu’s son... is that what you wanted? Here then, dirty whore! [...] His eyes swollen with rage fell on the mocking belly and he started kicking her with his feet, yelping with satisfaction, as if every kick took a burden off his chest. Ana’s crossed arms tried instinctively to shield the fierce blows that threatened the fruit of her sin [...] Vasile Baciu dragged her inside, almost unconscious, closed the door and continued the beating fervently”. The next day Vasile “flung himself on Ana again, though she was covered in bruises, and beat her till the neighbors rescued her from his hands [...] From then on no day passed without beating her until he got tired”.

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hopes of happiness are shattered and she falls back into the same wretched life. Suddenly she starts crying bitterly [...] Later on Ion sits beside her and says coldly: - Why whimper now? You are not going to your death sentence”.

Ion and his father in law are in a constant fight for possessions; Ana is just a means, hateful for both. Because Ana does not succeed in convincing her father to transfer the assets to Ion, the latter begins to assault her physically for the first time: “with great lust he raised his hand and hit her on the right cheek, then with the back of his hand on the left [...] and hit her again over the eyes that looked at him in fear [...] You also want to crush me? You have no pity either? Ion spits with relief and goes into the house”.

At this moment the character's psychiatric condition develops into major depression. “Now she finally had to admit that Ion hated her and all of a sudden she wondered why she couldn’t see it until then?” The lack of hope throws a bridge between depression and the suicidal tendency (4).

Under the stimulus of unbearable psychological pain, Ana enters the realm of suicidal thinking (the incubation phase of suicide, during which the individual visits the idea of death and questions the need of dying, in this case under psychopathological sociogenic factors (5): “Ion comes into the courtyard yelling [...] lashed forward like a hawk and shouted [...] brandishing his knife: - Run, tramp, go away before I send you to hell!... and stay away from my house or I'll slice you to pieces! Thief [...] When Vasile saw her approach [...] he shouted through his teeth like a beast: - Don’t come to me, you broad, or I'll break every bone in you! You wanted a beggar... now stay with a beggar... Look at him! Isn’t he proud? Now you've learnt your lesson [...] Where will I go now, she wondered, and all the answers were gloomy [...] tempting her to put an end to her misery, as life was no longer worthwhile [...] That night for the first time she realized the abyss in which her life was thrown and the thought of death came upon her like a happy escape [...] like a tranquil shore where all pain and hope had disappeared.

Figure 2. Ana (Ioana Crăciunescu) – screen shot from the film „Ion”, after the novel with the same title, directed by M. Mureșan, 1980

In the rural society of the time, the woman was no more than a work hand, dowry and children bearer (6). While she brings the food for her husband in the field, Ana goes into labor and gives birth. Even at such moment Ion is full of contempt: “She knows fine well she’s due and she comes to lay in the field! Damn her stupid reckoning!”

Ana's nervous tension continues to increase and reaches a peak: “The feeling of being useless in the world follows her everywhere [...]. She lived, but without any hope, life had become a burden.” The moment of self destructive outburst, in which Ana embraces the idea of committing suicide, follows shortly: “When she closed her eyes she always saw the water and a heavy hand was pushing her towards it, like to a shore washed away of all traces and regrets [...] I shall kill myself, Ion. Yeah, damn well go and do that, this way I might get rid of you!” At this time the suicide victim communicates her intentions, sends desperate signals, trying in vain to communicate with Ion.

The characteristic features of major depression are described once again by the author: “She found no joy in life”. “She felt her heart dry and empty, like a bag thrown on the side of the road by an indifferent passer-by. Little by little her mind switched off.”

During the traumatization (the phase of putting into practice the preconceived self destructive act (5)), Ana commits a psychotic suicide by asphyxiation (hanging): “taking and unfolding the rope in her hands, she was full of joy [...] She rose on tiptoes, took the loop with both hands and put her head through [...]. She closed her eyes and tried to let go of the rope [...] The rope became tighter and tighter. There was no pain [...] She felt a tickling and had to open her mouth and eyes. Suddenly it crossed her mind that now she was going to die, she panicked and wanted to reach the ground with her feet. But she moved them in vain, her feet found no support. Then she got frightened and started to choke. Her tongue swelled and filled her mouth, so she had to put it out... Then her whole body tingly. She felt an immense pleasure [...] Her bulging eyes saw nothing. Only the tongue continued to swell, defyng and mocking, like a revenge for the silence to which she had been condemned all her life”.

The inner attitude of the suicide victim is ambivalent till the last moment: she wants self destruction and salvation at the same time (“it crossed her mind that that now she was going to die, she panicked and wanted to reach the ground and escape death”) (4).

Not long after, Ion would die too, killed by Florica's husband who discovered their love affair.

Margareta – the tragic comedy

Alexandru Kirítescu (1888-1961) is one of the most prominent playwrights from the period between the two wars. Gaitele [Jays] (initially titled “The Wasp Nest”), his main work, is a comic satire of the manners of the bourgeoisie of Bucharest in the 1930s.

The action takes place in the rich family originated from Oltenia, in Aneta Duduleanu's house, the widow of the boyar Tasse Duduleanu. Aneta together with her sisters, Zoia and Lena, are the “jays”, who pass judgments on everyone around, but display a suburban behaviour, playing cards and gossiping all day long, while their favorite entertainment is to watch funeral processions from the balcony (7). The play presents the evolution of the conjugal relation between Margareta, Aneta's youngest daughter, pregnant by the young journalist Mirecea Aldea. An orphan since the age of seven and very poor, Mirecea accepts to be Margareta's kept husband. „MIRCEA: [...] I really and truly believed that I escaped... forever escaped the dejection in which I was rolling till then...”
Initially Mircea represents for Margareta the ideal in life freed of the coarseness of her family. Pervaded by the comic language, the play is an outflow of wickedness, with constant irritation and interruption of the dialogue partner; thus a permanent tension is built, scattered with outbursts: at some point or other every character "shouts", "yells", "jumps", "jerks", or is "in the thralls of a terrible fury".

"MIRCEA: [about Margareta] She has complained of dizziness for four days... sometimes nausea... [...] No longer than today she threw up [...] WANDA: Meningitis is in the brain, auntie. ZOLA: [...] I meant the other... appendicitis... get her operated. (to Margareta). Don't be afraid of the knife, pet, otherwise the pus will break your bowels and you die within 24 hours [...] I am more of a doctor than any doctor. I buried three children and also mummy and daddy..."

Margareta’s drama slowly builds up. With a behavior detached from the typical Duduleni’s rudeness, she is held in contempt by her family.

"ANETA (to Margareta) [...] Oh dear, how stupid you are! Who you take after I couldn’t tell, as I was very smart [...] Just look in the mirror and see a face you got [...] MARGARETA: She’s not my mother, she’s my enemy [...] I can’t stand her"

As a constant laughing stock of the "jays", she considers Mircea her only moral support: ["LENA (to Margareta): Wait and see: it was like a big black water... You were on the shore with Angelica [...] you know... the one who died in childbirth [...] and the water was rising and coming and roaring... You wanted to jump in, but kind of shy. Then she grabbed you by the shoulders... ANETA: Who did, sis? LENA: Angelica, sis... and she pushed you into the stream... ANETA: But Angelica didn’t die in childbirth. LENA: Then how did she die? ANETA: Of peritonitis LENA (adamant): That’s childbirth! D’you think that Dumitrescu’s niece, Anuta, died of something else? ANETA: That one died of cancer. Cancer ate into her chest till it got to her heart [...] LENA (determined): Childbirth I say. Her breasts fevered with milk and gone to cancer [...] ANETA (to the other wailing two): Ho now, shrews, you’ll have enough time to weep her! [...] MARGARETA (who had listened in total silence, suddenly started to cry in a terrible panic that seized her entire body): Mireca!... Mircea!... Mireca!..."

Mircea expresses her despair regarding the atmosphere in her mother’s house: „MARGARETA (bursting out): [...] I’m sick of it!... I can’t stand it anymore... I’ll kill myself”.

Margareta suffers from a depressive disorder, caused by the continuous contempt and mockery from her family. The only thing that obstructs the depression to progress is her love for Mircea: “MARGARETA (simply): He is the only love I have in this world”. However, Mircea is seduced by Wanda Serafin, a woman of doubtful morals arrived from Paris, a niece of Tasse Duduleanu, to whom he confesses the lack of any feelings for Margareta.

“MIRCEA: She removed all emotion from her existence, there is such a void around her heart that nothing vibrates anymore, there is no life, nor feeling, except...
WANDA: You!...
MIRCEA (oblivious): Me.
WANDA: Horrible creature ...”

When she sees the coldness and lack of feeling in her husband’s behavior, Margareta undergoes the transition toward major depression: „MARGARETA (clinging to him in despair): Mircea, you don’t love me anymore!... You run away from me!... You’ve become a stranger [...] (between sobs): [...] I am so miserable... So miserable [...] Don’t you think it’s odd that I, the naive one – whom my family, my friends consider stupid – suddenly understand so many things?
MIRCEA: I admit! [...] You drove me insane with your fantasies, your insinuations! [...] (he shouts) You must stop, stop it now! [...] MIRCEA (roars into her face): Beast... You are truly one with your beastly family! [...] MARGARETA: Aren’t I? Aren’t I just?
MIRCEA: You are!... You may say that over and over, like an idiot! [...] [...] Monster!... Murderer! [...] MARGARETA (with tears in her eyes): Whatever you say, my love... [...] MIRCEA (turning his head, through his teeth): Hysterical woman..."

The moment of the self destructive outburst is when, due to the family indiscretions, Margareta finds out that Mircea has a love affair with Wanda. Traumatization follows shortly, Margareta commits suicide by a chemical method (overdose of opium infusion).

“ANETA (showing a pack of letters): Here! [...] Letters from your husband to Wanda. He writes her three a day... [...] IANACHE: Love letters.
MARGARETA (sustaining the blow): what... what... GEORGES (brutally): Mircea cheats on you with Wanda... Mircea is Wanda’s lover.
MARGARETA (deadly calm): It’s not true. [...] (During this time Margareta drops her head on the back of the armchair and waits. Georges reads). “I have barely left your arms and I already tremble with the desire to see you again. What poison have you dripped into my blood, Wanda?” (He stops)
MARGARETA (breathless): Read on... [...] GEORGES (reading): “I got home, I entered our room [...] Margareta slumped in her recliner she doesn’t seem to
leave at all now, gave me a dead smile. There was an awful smell of ether and bromide around her... Wanda, Wanda, if there wasn't for your love to... (he stops) [...] ANETA (impatient): Why do you stumble all the time? Can't you see the girl wants to know everything? GEORGES (upset): Wait, I can't make out the writing, it's all scrawled...

IANACHE (sarcastically): His hand was shaking... he was excited... [...] GEORGES [...]. “...to support me, to give me strength [...], I would empty the bottle of laudanum I see on the medicine table, the drink of oblivion and of nothingness...”

MARGARETA (simply): Read... (She goes to the medicine table and pours a full glass from a red labeled bottle, while Georges reads on [...] All of a sudden Margareta drops the glass she was holding, which breaks with a noise. She falls on the floor. Georges, with a strangled voice) Margot!...

ANETA (cries): What did she drink? What did she drink? [...] The bottle with the red label... What did she drink? IANACHE (rushes to the table, takes the bottle and reads): Laudanum.

Margareta's suicide distresses Mircea emotionally and he refuses to continue his relationship with Wanda.

In lieu of conclusions

All three characters come from well-off families, and in the etiology of their psychopathology we find social factors – the struggle for wealth of the people around them. While Tincuta marries somewhat forcibly, Ana and Margareta love their husbands and the revelation of unreciprocated feelings is an emotional shock.

Starting from her husband's humiliating behavior and the constant conflict between husband and father, Tincuta initially develops an anxious-depressive disturbance that progresses into major depression; she succumbs – most probably – to secondary conditions. Tincuta’s psychopathology is relatively briefly presented, in a simple, swift manner. From a medical point of view some of the stages of the disease evolution are omitted, while the precise cause of death is left out; one may guess, however, that certain conditions secondary to major depression indirectly led to her death.

Ana's psychopathology emerges under her father and husband's physical and verbal aggressions, together with the contempt of the people around her. Initially she develops an anxiety disturbance, which quickly shifts to anxious-depressive disorder and ends in major depression and suicide. The onset and evolution are presented accurately and in detail from a medical point of view.

Given the literary genre of the work of origin, Margareta's case is presented with relative accuracy from a medical viewpoint. Her psychopathology could have also been worsened by dysgravidia. Held in contempt by her family, rejected and betrayed by her husband, Margareta undergoes the stages of depressive disorder to suicide.

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The authors had an equal contribution and approved the final version of this article.

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No potential conflict of interest to disclose.

REFERENCES


***
THE DELUDED PERSON AS AN ACTOR IN AN ABERRANT SCENARIO

Mircea Lăzărescu¹, Marinela Hurmuz²

Abstract:
The paper develops the idea of interpreting delusion based on Gallagher's "multiple realities" perspective. The self is considered to be permanently involved in different scenarios, including fictional ones, such as watching a play or reading a novel. The narrative theories of personality also discuss the involvement of the self in various scenarios, but with the possibility of returning to its basic, biographical identity. Delusion is interpreted as a "fall" in a role of an aberrant scenario, which the subject cannot escape from. The multiple realities are discussed from Mircea Eliade's perspective regarding the sacral time of the myth that forms the background for the time and structure of the fictional narratives. The normal psyche is characterized by a meta-representational structure, which allows the self to play the roles in different life scenarios. Delusion is interpreted as the alteration of the "autonoetic consciousness" and of the "mental time travel" structure.

Key words: delusion, fictional realities, self, mental time

INTRODUCTION

Delusion is still defined by reference to Jaspers (1997), who considered it an abnormal, incomprehensible belief in a false idea, which takes place through a psychopathological process. In a manual of descriptive psychopathology, it is stated that:

"For Jaspers, the characteristics of delusions are that: (a) they are false judgements, (b) they are held with extraordinary conviction and incomparable subjective certainty, (c) they are impervious to other experiences and to compelling counterargument and (d) their content is impossible" (Oyebode 2008, 122).

During the last decades, there has been an increasing number of psychopathological studies regarding delusion, especially due to the development of cognitivism. The "top-down" and "bottom-up" theories consider delusion a false belief (Bertolotti 2010). Lately, this thesis was frequently argued (Stephens 2009). Recently, Gallagher (2009) suggested another approach of delusion, from the perspective of "multiple realities" (MR). He stated that the person is living in various realities in his everyday life, for example when going to the theatre, when reading a novel or when playing a video game. These realities are different from the practical reality of the everyday life. So is delusion, which absorbs the subject in a particular reality. Still, when living in the "multiple realities", the normal subject is able to return to his normal life.

We will try to develop Gallagher's hypothesis starting from the perspective of the narrative psychology of the person, referring to the special temporal dimension of the narrative reality and considering the particular domain of the sacral myth. For this purpose, we will discuss Mircea Eliade's interpretation of the special temporality of the myth and of cultural narrativity.

DIFFICULTIES IN THE STUDY OF DELUSION

Before presenting our own thesis, we will shortly highlight four problems which make the study of delusion difficult.

The first difficulty lies in the fact that delusion is part of multiple clinical contexts. We consider that, from a psychopathological perspective, the delusion which characterizes the "Persistent delusional disorder" in ICD 10 (F22) (WHO 1992) is more relevant to our purpose than the schizophrenic delusion.

A second aspect concerns the frequent correlation between delusion and different perceptive disorders, such as the "salience" phenomenon, illusions, hallucinations, derealization, sensitivity, "centrality", reference. These inferences draw attention to the fact that the psychic structure disturbed in delusion is a trans-situational one, implying a meta-representational level.

The third problem implies the various notions used to characterize delusion, in different domains. We can mention some of them: belief, truth, evidence, doubt, certainty, idea, experience, argument, proof, faith, conviction. These terms are also used in philosophy. The ancient skeptics talked about "doubt" and so did Descartes. The concept of "idea" was mentioned by Platon, later by Kant and it currently has different meanings.

The fourth difficulty is related to the classical problem of the primary delusion. In his main article in 1910, Jaspers made a difference between the abnormal, but comprehensible prevalent process and the incomprehensible primary delusion (Jaspers, 1963). The primary delusion emerges in a different way, being preceded by a delusional mood. The subject feels that everything around him has a special, mysterious significance related to him (the feeling of "centrality"). At a certain moment, a common perception receives a special meaning and "clarifies" the delusional, incomprehensible theme (delusional perception). It is the moment when the "psychopathological process" takes place and "moves" the subject on the incomprehensible orbit of the primary delusion.

However, the clinical experience proves that a...
progressive variant of the emergence of delusion is also possible, even in the case of the delusion of jealousy. For example (a personal case):

“A 35 years old man progressively gets to the conclusion that his wife is cheating on him with her boss, with all her colleagues and, later, with all the members of the administrative community of the town. For this reason, they move to a different city. There, the history repeats itself. The situation becomes unbearable, because people start to laugh at him on the street. After moving to another place, having the same problems, the man accepts the admission in a psychiatric unit, 4 years after the onset.”

The delusional jealousy and the transition from normal jealousy to prevalent and delusional ideas have been studied by many authors (Shepherd 1990, Enoch 1991). All of them agreed that a progressive evolution towards delusion can characterize jealousy; and also dysmorphophobia, hypochondria or the ideas of reference, as classically described by Kretschmer (1974). Two decades ago, Hollander (1993) suggested a possible obsessive-compulsive spectrum and imagined a continuum between the pole of obsessive uncertainty and the one of delusional certainty, passing through the over-evaluated ideas; the anxious-phobic phase could be placed at the beginning of this continuum (Fig. 1).

Although we agree with the idea of the continuum, we also need to accept the idea of a “disruption” or “fall on another orbit” in the case of delusion (Fig. 2).

The slowly progressive emergence of delusion and the sudden occurrence of the primary delusion are complementary. The last one is important for understanding delusion, because it highlights the existence of a psychotic level. This level can be considered similar, but specifically different, from the psychotic level of mania, major depression, depersonalization, disorganization, catatonia, obsessionality etc. The question would be: what is the psychic structure – centered by the self – which is impaired in this case of “psychosis” in general and in the case of delusion in particular?

**PERSONAL THESIS**

Our own thesis states that delusion can be characterized by an abnormal identification of the subject with a special role in a narrative scenario, a real or a fictional one. This scenario refers to the subject's identity, including: his state of being, his value, relationships, situation or his own self. For example: the role of a sick, dysmorphophobic, spied, persecuted, over-capable, guilty, incapable person, the role of someone who has a special mission given by God etc. The presence of a narrative scenario leads us to the “multiple realities” described by Gallagher.

From a phenomenological-existentialist perspective, the deluded person can be compared to an actor playing the role of King Lear or Othello. In the same way, an obsessive person is similar to someone who is permanently preoccupied with the construction and cleaning of a house and a manic person with someone who takes part in a New Year's Eve carnival. The obsessive person becomes deluded only if he enters the role of a person who is in great danger of contamination or who is guilty for a possible danger produced by his magical thinking. Similarly, the manic person becomes deluded only if he takes the role of a character who is solving the world crisis or who has the mission of saving humanity; thus, who is transposing himself into a narrative scenario.

Our thesis highlights that the “idea” lying in the center of the delusional belief is characterized by an identity role in a narrative scenario. This approach leads to Tomkins' narrative psychology. Tomkins, cited by McAdams (2008), suggests that the person is continuously generating dramatic scenarios for the problematic situations of his everyday life. He is the author and the actor in these scenarios. In normality, he is permanently part of various scenarios with different durations. He can evaluate their importance and can get out of them whenever he wants to. But he is constantly maintaining his biographical self identity, his agency and the ownership of his creativity regarding the events in which he is involved. Narrativity is both implicit and explicit. Personal narrativity implies the use of language and expresses itself through different imaginary scenarios, dialogues with oneself, biographic reports, potential or real narrations of situations and events. All these can be narrated in different ways and moments by other people or by the subject, as memories. They can be studied systematically, as McAdams' narrative psychology did, for example. By playing different roles in multiple narrative scenarios, the subject is living on various levels with different objectives and different durations. This aspect is related to the study of the “mental time travelling” function, in relation to Tulving's autonoetic consciousness (1983). The subject
expresses himself through a variety of selves, on the background of a basic biographical identity and time. Hermans has also studied this aspect (2009), based on James' ideas of the multiplicity of selves (1996).

In the case of delusion, a certain scenario becomes dominant. The subject collapses in a specific role, which merges with his own identity. The person's receptivity and creativity for the involvement in other scenarios decrease. The aberrant scenario is lived by the subject in relation to the real world or to a fictional one. E.g.: “A patient shoots another person believing them to be an enemy assassin and himself to be the Queen's personal bodyguard” (Oyebode 2008, 122).

“A manic patient claimed to be Mary, the Queen of Scots. She accepted that the queen in question lived and died centuries ago but claimed descent from her and felt fully entitled to say that she was she” (Oyebode 2008, 126).

A patient explains that “everyone smiles and nods when they see me because I have been sent by God to communicate with people about evil and I have a letter from the Pope as proof”. (Oyebode 2008, 134).

Understanding the delusional idea as the placement of the subject in an aberrant identity-relational role in a narrative scenario is consistent with Gallagher's point of view. He interprets delusion from the perspective of multiple realities (MR). Gallagher (2009) goes further with Shultz's interpretation of James' concept of “sub-universes” and discusses the realities which are different from the everyday life: the reality lived when going to the theatre, to the cinema or when playing a video game. The subject can temporarily enter the role of the characters of these realities and can take part of their adventures. Similarly, in his dreams, he becomes the hero of some particular events. Still, in normality, the subject is in permanent contact with the everyday events and he can always return to his real life after spending time in the fictional or virtual reality.

We believe that Gallagher's idea deserves to be analyzed and developed. It implies the evaluation of the identity roles from the aberrant scenarios of the delusional sub-universes and an analysis of these multiple worlds. It highlights the psychological characteristics of the person living in the realities of the theatre plays, novels, stories, myths or games. In relation to these realities, we can better understand the subject’s “fall” in the abnormal situation of “being in the world”, in a parallel reality than the one of everyday life; a reality which absorbs him and which he cannot abandon on his own.

**THE PROBLEM OF THE MULTIPLE REALITIES**

The deluded person „falls” in a special world, parallel to the many worlds which form the „socio-cultural realities” (SCR). When analyzing delusion, psychopathology needs to take into account not only the impairment of the psychological processes (perception, cognition, ideation, memory, representation, imagination, will, motivation, expectancy, evaluation, belief etc), but also the realities of the multiple human worlds, formed by novels, theatre, history, myths, in which the person lives during his life. The SCR become part of the individuals through the process of education.

The subject has at his disposal the „multiple realities” (MR) and he is permanently connected to them in his everyday life. He can enter these realities if he needs or if he wants to (Table 1).

<table>
<thead>
<tr>
<th>Table 1. The main realities connected to the SCR</th>
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<tbody>
<tr>
<td>a) dreams;</td>
</tr>
<tr>
<td>b) the religious and mythic reality, when participating to the sacramental rituals of prayer or other religious practices;</td>
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<tr>
<td>c) going to theatre plays or movies; it also includes the reality of an actor who is performing in a play and who is transposed into a fictional reality. A special case is the one of the writer of a play, who is directing and then playing a role in it;</td>
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<tr>
<td>d) the reality of video games;</td>
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<td>e) the reality of different feasts, such as carnivals;</td>
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<td>f) reading a novel or listening to stories; this category also includes the special case of the novel writer, who “gives life” to special characters and situations;</td>
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<tr>
<td>g) listening to or participating in everyday narrative histories regarding known or unknown persons;</td>
</tr>
<tr>
<td>h) the artistic creativity, for example poetry or painting, but also the scientific, theorectic creativity;</td>
</tr>
<tr>
<td>i) creativity in the domain of mathematics and philosophy;</td>
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<tr>
<td>j) the trance and mystic - ecstatic states; visions;</td>
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<tr>
<td>k) the delusional reality.</td>
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The most important themes related to delusion are the c),d),e),f),g) and partially a) situation. The b) and c) situations are related to mania. The h),i),j) situations are especially important for schizophrenia. The a) situation is met in delirium and may have some correlations with delusion.

Some of these more or less “fictional” realities are common for everybody. However, there is no operational definition for the normality of the persons who are involved in these realities. The normal person takes part in these realities with his whole cognitive and imaginative functions, in a special existential temporality, during his entire life.

The discussion of the dream in this context is important for highlighting the personal and subjective character of the states we describe in our thesis. All these realities involve the “subjective world” of the person. Dreams are present in a different reality than the one of the physical and bio-psycho-cultural human world. However, they derive from the everyday life. This aspect reveals the fact that, in all the “sub-universes” of the SCR, the subject partially detaches from the environment and his availability for connecting to the world is temporarily limited. When watching a play or while reading a book, the subject does not think about something else. He is “isolated”, but, in the same time, he remains connected to the SCR. This connection is also present in the case of creativity (h) and i) situations).

The subject is involved in different scenarios and roles not only by entering the multiple realities which are parallel to the SCR. He is also playing these roles inside the SCR, during his everyday life.

The sociology of the 20th century has developed the concepts of “social status” and “social role”. These concepts apply to the family institution as well. The person can have different statuses: engaged, married, divorced, widowed etc. and, in the same time, he has
different roles: the role of a parent, child, relative etc. Another perspective of the individual roles considers the “dramatic” process of human existence. People fall in love, they get married, they argue. Children are planned, born, they grow up, they have their own families, they build a house etc. The old person retires, has a will, and leaves behind a material and spiritual heritage. All these processes and events are in a continuous development, but they can also be narrated as part of the personal biography. The events which happen in real life are similar to the ones happening in a play or a novel. For example, a husband can be jealous in the real life, but also in a tragedy. The exaggerated preoccupation for illness, errotomania, persecution or the will for harming someone are realities of the SCR, but can also be present in the fictional narrative realities of the movies or novels. Everyone is permanently playing the social roles of the cultural society he lives in. But these scenarios are part of the subject only to a certain level of his psychic structure. From the level of social roles, the subject can “slip” to the delusional “sub-universes”.

If we consider the MR concept and the delusion viewed as an aberrant involvement of the subject in a certain “sub-universe”, we need to ask ourselves: what is the basal ontological structure of these human “sub-universes” or “sub-realities”? For understanding these realities, we suggest a model based on the special narrative temporality of the sacral and profane worlds, described by Mircea Eliade. The narrative time of the myth which evokes the origins of the world is different than the narrative time of the profane actions. The sub-universe of the human practices, as well as the one of the novels, could be explained from this perspective.

In his classical books “Treaties on the history of religions” (1987) and “The myth of the eternal return” (1971), Eliade analyzes the fact that the whole human history has been structured by the polarity between the sacred and the profane. In every culture (until the end of modern era), there has been the belief that the unnatural forces had created the world in the holy time of beginnings. The sacral practices, the rituals and religious ceremonies are an important part of human existence. People use the sacral rituals in order to invoke the time of beginnings. They tell the mythic stories in a special place and time. In the same way, the legends and histories of a community draw the people out of the time and space of the everyday preoccupations. By listening to these stories, they ignore the reality of the present time and they are placed in a different time, the one of the “once upon a time” narrations. Besides the present “reality” of the environmental world, people also live in the temporality of other narrative realities. The paradigm of these temporalities is the originary time of creation. Eliade believes that this model can also be applied to the special reality of literature.

In his book “Aspects of myth” (1963), published in the USA, Eliade discusses the fact that people need the “stories” and they need to enter the foreign universes created by stories. It is part of the human condition. Every person is fascinated by different narrations, by the stories of historic or literary characters. Reading a novel or a history implies the exit from the time of the everyday life. A comparison can be made to the traditional societies' practices of reciting a myth. In both situations, the person “is getting out of” the personal and historical time and he is entering a fabulous, trans-historical time. The reader is placed in a foreign, imaginary time. Thus, the novel has access to the primary time of the myths.

The immersion in a delusional state and in a fictional delusional scenario can be compared to the normal, periodical entering of any person in the narrative time of a novel or a religious ceremony. Each person is living in the “multiple realities” that have their own specific time. The difference is that the deluded person “is falling” and is “locked” in his fictional, absurd scenario. The patient acts according to the rules of this particular reality and he is not able to get out if it. The delusional world is simplified, rigid, inflexible and the complex temporal structure of the person is blocked. The identity self is the main structure which is impaired in the delusional pathology. The deluded person over-identifies himself with his aberrant role. On the contrary, in the case of the shizo-hebephrenic disorder of the self, described by Minkovski (1927) and Parnas (2011), this thing is not possible any more. That is why the schizophrenic delusion is bizarre and depersonalizant.

This interpretation of delusion implies the problem of narrativity and human language. Thus, it is correlated with Crow’s approach of psychosis, who considers that schizophrenia is a price paid by evolution for the development of language, 150000 years ago.

**DELUSION AND THE META-REPRESENTATIONAL LEVEL**

We cannot describe the correlation between delusion, narrativity and temporality without considering the psychological structure where this process develops.

It needs to be a representational and meta-cognitive structure, which is connected to the narrative biographic identity and also with the situational experiences of the person, which have different temporal durations. This meta-representational structure is connected to the narrativity of the multiple realities we have described. The subject is permanently evaluating the situations in a meta-cognitive way. He is imagining problem-solving scenarios, based on probabilistic models. These scenarios also refer to his long-term relationships, to identitary and self-evaluation aspects. Besides the present situation, the self is also part of various projects of different durations. Tulving’s model of the Mental Time Travel can be mentioned here.

We suggest the following model of the self as a whole (Fig. 3).
In delusion, the meta-representational structure of the psyche involves the subject in the role of a hero in different scenarios which takes him out of the context. The meta-representational structure can also be involved, in a different way, in the mood and obsessive-compulsive disorders (Fig. 4).

In the schizophrenic delusion, the subject is depersonalized, so that the hero in the delusional scenario becomes an abstract entity, almost completely absorbed in fiction. Schizophrenia is based on the pathology of the minimal, nuclear self and not the one of the biographic, narrative self which places the subject in different social roles. Through the collapse of the intimate-public relational structure, the self loses his autonomy. This aspect is expressed by Schneider's first rank symptoms. That is the reason why the schizophrenic delusion is only one special, atypical form of the delusional pathology. From this perspective, the “primary delusion” discussed by the psychopathologists in the last decade might not be the ideal model for the study of the delusional pathology.

CONCLUSIONS
The interpretation of delusion as the “fall” of the person in a role of an aberrant, rigid and fictional scenario, from the perspective of multiple realities, represents an idea which deserves to be debated and studied in the future.

REFERENCES
THE RELIGIOUS DELUSION AND THE “MULTIPLE REALITIES” PERSPECTIVE

Mircea Lăzărescu¹, Jenica Blajovan², Marinela Hurmuz³

Abstract
The religious delusion has not been the focus of many clinical and psychopathological studies. A possible reason could be that it cannot be easily assessed through the cognitivist research methodologies. An interesting approach is the one of the “multiple realities” (the fictional realities of literature, theatre, virtual computer world etc.), an idea recently developed by Gallagher. The cases of religious delusion are characterized by a psychopathologic process of depersonalization/trans-personalisation, by entering a particular role in a “special mystical world”; a simplified and distorted one. The paper discusses 12 cases of religious delusion from the Case Register for Psychosis Timisoara. It focuses on the role of narrativity and the process of identification with characters from the mythical narrations in delusion. It suggests the development of phenomenological-existentialist research in the domain of delusion from the multiple realities perspective.

Key words: delusion, religious delusion, multiple realities, psychopathology

Delusion and the hypothesis of the multiple realities.
Jasper’s classical definition of delusion (1) considers it a judgement (idea, thought, theme) held with an extraordinary conviction, with an incomparable subjective certainty, which is impervious to other experiences or to compelling counter-arguments and which has an impossible content.

Understanding delusion as an abnormal belief is maintaining this problem in the field of cognitive disorders, as it used to be in the 19th century (2). The recently growing interest of cognitivist psychopathology suggests the development of partially validated theories, such as the “bottom-up”, “top-down” or the deficit in abandoning a false idea models (3,4). The interpretation of delusion as a false belief was challenged by several arguments (5,6).

A recent approach, developed by Gallagher (7), suggests the interpretation of delusion from the perspective of “multiple realities” (MR). This idea is based on the fact that a person is not only living in the physical reality, but also in other more or less fictional realities, which are part of his everyday life and which he can access for short periods of time. For example: watching a theatre play, reading a novel, playing a computer game. The scenarios of the fictional realities are characterized by a different spatial, temporal and causal structure than the daily events. When entering these realities, the subject partially extracts himself from the everyday situations and becomes part of different events, being able to identify himself with the fictional heroes of those worlds. Later, he is able to re-engage in his current life. Gallagher writes: Besides the “world where we work, earn our salary, socialize, enjoy family life, and so forth, there are also multiple other realities that take us away from everyday reality. If, for example, I read a novel, or go to the theatre or the cinema, or play a video game, I spend a couple of hours escaping into a different sort of reality which opens up in the pages, on the stage, or on the screen. In such realities, I may not have a role to play as myself, and I may identify with one or more of the characters presented in these different media. In dreams or even daydreams or various fantasies, I may more actively play a part as myself, or as a modified variation of myself, but not one that I usually play in my everyday reality”.

Developing Gallagher’s idea, we suggest that delusion can be interpreted as a “fall” of the subject in an aberrant role of a fictional scenario. He is not able to return to his basic condition; he identifies himself with a fictional hero and he thinks and acts by the logic of the fictional world, different from the everyday life. This idea, which has not been systematically developed so far, can be correlated with the existent studies regarding the narrative psychology of the person, developed by Tomkins, Hermans, McAdams (8, Note 1). The issue of the MR is still under discussion. Important references to this theme can be found in the writings of Mircea Eliade (9, 10 Note 2). Eliade discusses the difference between the sacred and profane time. He believes that the fictional realities can be placed near to the special area of the anthropological temporality, exemplified by the mythical and sacral narration. The sacral “world” is a “reality” for people who believe in God and it deserves special attention. This type of reality is not mentioned in Gallagher’s examples.

The religious delusion and its particularities.
From this perspective, the religious delusion is of particular interest. It can be considered one of the three main delusional themes, the other two referring to the social interpersonal relationships (paranoid, erotomanic delusion, delusion of jealousy, of surveillance) and the person’s attitude towards his identity and state of being (preoccupation for disease, for the body image, positive or negative abilities, invention, particular filiation, new identity). The religious delusion is only vaguely

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mentioned in the manuals of diagnosis and it is less studied than the other types of delusions (11,12, 13). Sims (14) discussed the religious delusion from a psychopathological point of view. This theme has been less common during the 20th century in western civilization (15). The religious delusion can be found in most of the psychotic disorders, especially in schizophrenia (16,17,18,19,20,21), delusional persistent disorder and bipolar disorder. It is more frequently expressed through a special mission given to the patient by God for fighting the evil or saving the world. It is sometimes accompanied by his identification with one of the divine figures. The presence of the devil can be experienced as body possession or through thought and behaviour influence (22).

A special feature of the religious delusion is the fact that it refers to a supernatural reality which is organized in a mythical, narrative way and it is traditionally, socially and culturally admitted as a “special reality”. The sacral figure is accepted by official institutions and current community practices. The sacral universe is an undoubted reality for the normal believer, which is parallel with the physical and social everyday reality. It is a far away, transcendent reality. The access to this reality is possible through individual and collective prayers. The characters of this world are omnipotent in relation to humans and they have access to one’s intimate life.

In Christianity, the main characters are God, Jesus Christ, the Holy Spirit, Virgin Mary, who have family-like relationships. In addition, there is the Devil. The main event is the Death and Resurrection of Jesus. The most important themes are: fighting against the devil, saving humankind, the End of the World. God takes care of man, he protects him and can send him special messages and missions. The religious delusion is, by definition, a relational one, expressing the subject’s relation to the supernatural, omnipotent characters. The profane relational delusion in the paranoid disorder refers to hostility, surveillance, cheating etc., exceptions being the eroticomanic delusion and the undefined relationship. As a whole, the social relationships develop on an intimate-public diagram. In regard to the sacral, mythical characters, they are, by definition, in a faraway place and they can only be approached indirectly. In delusion, they get closer to the subject and they can directly act upon him.

The sacral mythical scenario, the multiple realities (MR) theme and delusion.

The multiple realities hypothesis refers, in Gallagher's description, to the cultural narrative universe of the theatre, literature, novels, virtual reality. The mythical reality is not mentioned.

The characters of the narrative worlds – theatre, literature, history, biography – are placed in an intermediate position in relation to the physical social reality of the everyday life. Generally, they are part of the profane reality and they are not characterized by omnipotence, like the characters of the sacral world. In these “multiple cultural worlds”, we can identify some areas that are closer to the supernatural reality (e.g. witches, aliens) and other closer to the common existence (historical characters, biographical heroes). The sacral instance is traditionally an originary, “world-creating” reality. This is the reason why the religious delusion is a special delusional theme which might have a psychopathological value that can clarify some aspects of this psychopathologic syndrome.

In delusion, as well as in other psychopathological states, the psyche's structures are undifferentiate themselves, affecting the specific anthropologic spatiality, temporality, causality and the identitary structure of the subject. Temporality is centred by the present time, which lies between the remembered past and projected future. Spatiality refers to the anthropological distance on the intimate-public axis and to the objective closeness. Causality implies the origin and occurrence of a phenomenon and the way of action, including thinking and language. The subject’s identity has a complex structure. It includes his social identity (name, identity card, marital and professional status, biography), his subjective belonging to the self, the differentiation from others and the environment and the sense of agency and ownership of his experiences. Moreover, it implies the global feeling of self-identity. The impairment in all these areas needs to be explored in delusion.

**MATERIAL AND METHOD**

The paper analyses 12 cases of religious delusion. They are part of the Case Register for Psychosis Timisoara. The register includes a total number of 1618 new cases of psychosis during the period 1985-2004, out of which 728 cases are still under observation. This sample has been analysed with different aims until present. During their evolution, 225 cases presented religious delusion.

The purpose of the study is to analyse and understand the religious delusion from the MR perspective. The paper does not discuss the statistical clinical and evolutional characteristics, but the phenomenological aspects of the 12 cases. The subjects present religious delusion characterized by grandiosity ideas of special mission given by God or identification with mythical and sacral characters. We try to analyse the depersonalization/trans-personalization process of delusion. This process transforms the subject in a special character – a character of the sacral reality, if we consider the particular atmosphere of the religious delusion - but also in other historical or fictional characters, in cases
concerning other types of delusions.

Case studies

Case 1. A 41-year-old woman developed a psychotic symptomatology with manic disinhibition and delusion of divine mission: She is chosen by God and she has the mission to fight the devil. God talks to her every day. “The Holy Spirit is talking through me”. God has chosen her to be a prophet, because she is “clean, she does not lie, she has not committed adultery and she has, on the back of her hand, a sign indicating the place of the nail from Jesus’ crucifixion...” “She has a bitter taste in her mouth from the wormwood Jesus had to drink and her body smells like incense”. God protects her and influences her, she has thoughts which are “given by God”, “her thoughts can be read with God’s help”. She feels she is being followed by people, because “people are devils”; she realized that and she feels “a cold shiver in her back head”. Delusion of divine mission is correlated with the identification with Jesus; her mission is similar to the one of a prophet. Her intimacy with divinity expresses through thought broadcasting and influence. The religious scenario expands to her relationships with other people, which are “devils”. In most of religious delusion cases, there are particular aspects of Schneider's first rank symptoms. This deserves a special discussion, the current analysis referring to the identitary-relational problem. Her special mission and identification with Jesus places the patient in the supernatural world. She feels protected by God, in the same way a child is protected by his parent against other people's harm. This closeness and familial intimacy gives a natural explanation to thought broadcasting and insertion, if we consider the fact that every parent can know and influence his child's thoughts.

Case 2. A 42-year-old woman develops a religious delusion... “she feels that God is inside her and He speaks through her mouth...she has to pray for the whole world...” she feels that she is charmed by her neighbours and mother-in-law, who want to harm her and she feels the para-psychological influences... “Jesus speaks through her voice...she can do anything”. Even if the identification with God and the special mission are present, people are also part of her scenario. However, they are also “contaminated” by the supernatural world which the patient has entered, because they are able of doing charms. The identification with a divine character is suggested by the fact that Jesus borrows her speech and assures her omnipotence.

Case 3. A 44-year-old man has a slow onset of psychosis, during a 2 year period, presenting a delusion of grandiosity: he feels that he has been sent on earth by God, he feels Jesus in his body and he has the mission to save the world from disasters. He has special powers which he uses for people's benefit; he is a visionary, everything he thinks happens. That is why he avoids reading negative articles in the media or thinking about them. When he walks on the street, people want to touch him in order to steal his energy, because he has supernatural powers; the people follow him on the street. He is also monitored through the radio and TV. When he had crossed the country border, a storm started: “it was a divine sign which has warned him not to leave the country”. When he looks at the moon or at the Bible, he sees God, the angels and all the saints. Delusion of special abilities correlates with the special mission and identification with Jesus. His extraordinary capacities are not oriented towards fighting the devil, but they can influence human nature and behaviours. He has “common” supernatural capacities for someone who is part of the “divine world”. People follow him on the streets and through the radio. The subject lives in a supernatural universe, where he is in an intimate relationship with the biblical characters. But this is something usual for someone who is at the same level with Jesus, whom he feels inside his body.

Case 4. A 22-year-old man believes that he is the Son of God and he has to give people presents, bread, fish... he considers himself the chief of the Foreign Legion and he owns the files of the Timisoara Revolution...he will play in a porn movie...he will buy the Psychiatric Clinic where he is admitted and he will give the clinic his name. He preaches the voice of God and he will go to Heaven because his soul is clean and he has no sins.

The attribute of being the Son of God is combined, in an imaginary and meta-representational way, with other megalomaniac social and political roles. By entering the delusional world, the subject can become a “character” in fictional scenarios. The religious scenario and the role of the Son of God are in the main place. But the subject can also develop other roles and scenarios, closer to the world he is living in. Thus, the identitary role of the Son of God may associate with other identities which can develop in a narrative fictional scenario.

Case 5. A 44-year-old man, during a 3 month onset of psychosis, perceives and interprets different signs which tell him that he has to become a believer... he is sure that the end of the world will be in 7 months, that God sends signs which only a few persons can understand. While waiting the end of the world, he refuses food and he only drinks water from a fountain in front of a church, which he has dreamed and has been guided to. He is sent by God, he understood from the signs that he will be crucified in the front of the Cathedral in Timisoara, he is guided by the divine power and he can hear his own thoughts. God shows him in his dreams persons who need him to cure them and he shows us two persons which he has already cured through the power of his hands and faith.

The new identity of the subject, the “God's chosen one”, allows him to understand the hidden signs showing the end of the world. The identitary transformation goes even further, towards an “imitation Christi”, crucified in the front of the Cathedral in his home town. Schneider's first rank symptoms develop in this fictional atmosphere.

Case 6. A 32-year-old man develops a delusion of jealousy, he feels followed and watched on the street, then he believes that he is charmed... Later, a religious grandiosity delusion develops: “I am the light of the world, I was sent on earth by God. At Easter, everybody can take light from my angel halo...I am a very important person, everybody has heard about me”. “Satan takes the neighbours' image in order to monitor me, I don’t know with whom I am talking to any more”.

The grandiosity expresses itself in a metaphoric speech (“I am the world’s light”). The paranoid delusion is correlated with jealousy, sensitivity, charming and demonic delusions.

Case 7. A 41-year-old woman has a first-episode psychosis with paranoid delusion, symptoms of thought broadcasting and auditory hallucinations. In the second episode, a grandiosity religious delusion emerges: “I am equal to God”. The paranoid symptoms are less expressed.
The relationship with divinity is not necessarily one of subordination, mission or identification; the main aspect is that the patient is part of the same world as God. He has the same position, he is his equal. In most cases, the identitary scenario is explicitly expressed.

Case 8. A 35-year-old woman presents paranoid delusional episodes (2001,2002)- delusions of persecution, poisoning, but also religious delusion: “she feels a power descending upon her while she is praying”. At the second admission in the hospital, she says: “Jesus lives through me, I am Virgin Mary” and she calls her husband Joseph or Avram.

Case 9. A 54-year-old woman develops a grandiosity religious delusion, declaring “I am God”, in the same time with a paranoid delusion: she believes that she is followed by the police and security services, that her grandmother was substituted with a spy and she reports her to the police. She believes that the president and the head of the church are her children.

The identitary aspect does not only refer to the patient’s person, but also to the substitution of her grandmother. The delusion develops as a narrative scenario which includes real, important characters, who become her children.

Case 10. A 19-year-old man has a psychotic episode with religious grandiosity: “he is an important person, because the Holy Spirit has descended upon him”, “he will save the country form a disaster”, “people watch him in a particular way because of his importance”. “In the city, there is a witch who surveys him and knows his thoughts”, “everybody can read his thoughts through the radio and TV”, “he can influence the Romanian football team by only pronouncing the word “attacker””. “The devils' army has 999 million members, and if we turn the number upside down, it becomes 666-the devil’s number”. He does not get out of the house “because in the kingdom there is only modern science, there are no flowers or trees”. “As a child, an army of devils wanted to harm him, they pushed him in the devil thesaurus, he hurt his head and he has been feeling bad ever since”. “The devil controls his thoughts; the whole town, the whole country knows his thoughts”. “He is an important person, an Emperor or a Commander; his mother got pregnant with the Emperor, in the same way as Virgin Mary had and this is the way he was born”. “The Emperor will send a ship to take him home...or to the Kingdom or to Heaven, he does not know exactly where”. “he fought the devils and he won”...“he became free”.

The religious and grandiosity delusions develop in a narrative form, with fairytale elements. His father is an emperor and he was born in the same way Jesus was born. The transposing of one's identity in the fictional narrativity constructs a narrative character who detaches form the bodily self in the present person.

Case 11. A 33-year-old man develops grandiosity religious ideas, having a bizarre behaviour. He is sure that he has a new identity, inspired by the historical literature. “He is the good soul of Napoleon, whose uniform he will wear, and he will speak on his behalf. His soul has more covers, he is a genius, he is the people's man, a saint, his mission is to unify the catholic and orthodox churches, so that the people will pray to the East...” He refuses to eat and he forces his family to do the same “in order to purify themselves and become superior beings”... He is suspicious, nervous and he walks out in a careless outfit”. During another admission, he feels he is chosen by God, having the mission to bring peace and wellbeing on earth...he has special relationships with the supernatural forces...he is chosen by God to rule the world at the end of it...he is in an inner continuous fight in his relationships with God, Lucifer, the demons and the angels.

When psychosis manifests throughout the grandiosity delusion, the patient's identity is modified, sometimes embracing the soul of a historical character; but, essentially, his identity is placed in a supernatural existence, in a relationship with divine characters. He is not only imagining them; they are part of the world the patient is living in.

Case 12. A 22-year-old man develops psychotic symptomatology: at a certain moment, he sees Jesus waving; he was dressed in white and blue and, from that moment on, these colours gain a special meaning for him... Everything that happens is related to him and his intentions...There are references to his life on TV, because his thoughts and intentions are known and someone – probably the director of the movie inspired by his life – influences his behaviour and thought... He believes that his body is “signed”, at the level of his heart and hand, probably by God...His mother is not his real mother, but a woman who lives with him in the same house. Nor his father is the real one; his father is God or the director of the movie “Sunset Beach”; he is the main character of this series. He is smarter than the others around him and nobody can understand him.

The patient has an indirect relationship with Jesus, who only appears as an illusion of a person in the context of a delusional perception which leads to delusion. In this state, his identity changes: his parents are not the real ones, he is probably the Son of God, but he could also be the son of a movie director, in which he believes he is the main character. The delusion partially develops through a fictional, but worldly identity, as a movie hero.

**DISCUSSION**

The religious delusion is often centred by the theme of grandiosity, including a special mission received by God for fighting the evil, defeating the devil or saving the world. Sometimes, this special mission can derive from the feeling of having an extraordinary capacity and omnipotence. In most of the clinical cases, the grandiosity in the religious delusion is rarely accompanied by other manic bio-psychological symptoms: the acceleration of psycho-motricity with hyperactivity, logorexia, insomnia, agitation, sexual disinhibition etc. It is correlated with the superior level of the supernatural world. The subject feels that he enters and becomes part of this world through his identity and mission. Thus, he identifies himself with a special role. God can talk to the subject, can give him a special mission or He can send him divine signs. Often, a process of identification takes place, the subject feels that “he is the Son of God”. Therefore, he receives a divine position. The subject can declare: “I am Jesus Christ”, “I am Virgin Mary”, “I am God”. The identitary transposition places the subject into the role of a divine character. A patient says: “I sometimes feel I am God and other times the Devil”. It is a process of transpersonalization that makes the subject part of the supernatural universe. Traditionally, the notion of
“demonic possession” is also used. It is not only correlated with delusion, but also with the dissociative and trance states. In the religious delusion, we can talk about “possession by divine figures” – God, Jesus, Virgin Mary, the Holy Spirit”. However, this supernatural possession takes place in the context of intimacy with the sacral world. The religious delusion highlights the “trans-personalization” lived by the subject when he enters the delusional world. He becomes a “different character” who is involved in the scenarios of “a different world”.

Another important aspect is the fictional narrative characteristic of the religious experiences. The subject enters a fictional world, a world of narrativity, history and stories. Mircea Eliade (10) considered that each sacral mythology is a narration, a “sacral story” with characters and events. In the religious delusion, the sacral characters “fall” in a familiar, everyday lifestyle and relationships; hence, the divine myth becomes similar to the narrations of the everyday life, which particularly characterizes the “multiple realities” of culture and history. Not only Don Quijote can identify himself with different heroes. From this point of view, Eliade considers that “the time of the profane narration of the novels” derives from the “special time” of the sacral narration.

Therefore, delusion can be interpreted as the falling of the subject in a narrative scenario in which he identifies himself with a fictional aberrant role; and not only an impairment of the cognitive processes of interpretation. He cannot leave the delusional fiction – in the way a person can abandon a prayer, a lecture or a theatre play. The deluded person is absolutely convinced of his false idea, similarly to the conviction of a believer in divinity.

Unlike religious delusion, the paranoid delusion or the monothematic systematized one – hypochondriac, dismorphic, jealousy, erotoman, relational delusion – do not suggest, at first sight, the self-identification with a role or a character from a narrative fictional scenario. However, we can also talk about roles in these cases. The patient focuses his existence on a role derived from the social roles discussed by Pearson's sociology. From this traditional sociological perspective, the social roles do not only refer to the social statuses: gender roles, age roles (child, adolescent, adult, old man), professional and marital roles (engaged, married, divorced, widow). The sociologic doctrine also accepts transitory roles, such as the role of a sick, cheated, surveyed, persecuted person, the last one being real in the totalitarian regimes. Most of the monothematic delusions can be interpreted as an identitary disorder in which the subject “falls” into the identification with this kind of roles. Nevertheless, in these cases, the process of depersonalization/trans-personalization and the fictional feature of these scenarios are not obvious. Concerning the paranoid delusion in the schizophrenic form, the fictional scenario of the delusional universe sometimes becomes more obvious. For example, when the subject feels that he is controlled by aliens. Still, in the case of schizophrenia, the depersonalization phenomenon has special characteristics, with the loss of self-borders and the fragmentation of the self, this aspect makes the process of trans-personalization difficult. The person having schizophrenia frequently feels like an abstract character; or, as suggested by Stanghellini, a spirit without a body, a simple “entity”, impersonally monitored and controlled

(23).

The religious delusion gives us an important suggestion regarding the trans-personalization process in the psychopathology of delusion. The subject enters a role in an aberrant fictional scenario. These aspects can lead to important analyses in the psychopathology of delusion, especially because, at this level, we can discuss the differences and correlations between faith and belief.

CONCLUSIONS

The approach of religious delusion from the perspective of Gallagher's “multiple realities” suggests a process of depersonalization/trans-personalization which leads to the subject's identification with a role in an aberrant scenario, in a fictional world. The fictional aspect that characterizes the sacral universe in delusion is the consequence of a deficit and psychic de-differentiation induced by psychosis. If we interpret the cases of religious delusion from this perspective, we need to pay attention to the “multiple realities”–fictional realities closely connected to the everyday life, such as the reality of the theatre, novels or virtual computer world. By describing delusion as the fall of the subject in an aberrant role, the existentialist-phenomenological theme of “being in the world” is reviewed. This concept was approached by Heidegger in his book “Being and Time” and it has inspired the phenomenological psychopathology, especiallyBinswager's approach in the field of delusion (24). When discussing the “multiple realities”, Gallagher explicitly highlights this concept. It is an idea that has always been expressed during time by Kraus' phenomenological-anthropological analyses (25).

Note 1

The narrative psychology of the person considers the self as being involved in different narrations: one's own narration about himself in various situations; but also other's narrations of himself. The narrative self expresses by reference to the lived episodes of different durations and has its fundaments on the identitary structure of the person. From Dennett's perspective, this structure is the centre of the lived and narrated experiences. Tomkins suggested that the person can be interpreted through the role he plays in different scenarios which he develops for different situational problems. Hermans discussed the existence of several simultaneous “voices” of the subject. These psycho-sociological interpretations of the person develop an older idea of James (1890) regarding the multiplicity of the subject's selves. This view of a subject playing roles in different scenarios is in concordance with Gallagher's perspective of “multiple worlds”.

Note 2

Mircea Eliade developed the idea of the difference between the sacral and profane time. The mythic history that forms the base of a religious belief is considered to take place in a faraway time, in the sacral time of the beginnings and creation. During the religious rituals, people leave the profane time of work and everyday preoccupations and enter the mythic time of the origins. After that, they spend a short time of celebration, which is also different from the profane time. The religious ceremony can be considered the prototype of all human celebrations. Eliade suggests that there is a third type of time related to the time of the myth – the time in which the persons recall the historical events and stories that funded the culture and society they live in; and the
time of the fictional narrations experienced while reading or listening to a story or novel. This reference to the mythic-narrative time is comprehensively connected to the doctrine of the multiple worlds/realities.

References

ANTIPSYCHOTIC TREATMENT AND PSYCHOSOCIAL FUNCTIONING IN SCHIZOPHRENIA – RESULTS FROM ROMANIAN COHORT OF EUFEST STUDY

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INTRODUCTION

All chronic illnesses have the tendency to limit or even decrease the functional status of people that live with them, which is reflected in all life domains: psychological (accurate understanding and interpretation of people’s behavior), social (performing a social role), occupational (capacity to perform obligations at workplace, school and so on), leisure (capacity to enjoy spending time doing things that you like). Therefore the quest to achieve a better living for people having a chronic disease, it is of paramount importance and is in line with the current healthy-longevity promotion (1). Schizophrenia, dementia and depression represent chronic and debilitating illnesses listed by the international organisms as top priority for public health actions to reduce disability and improve the function and quality of life for people living with chronic illness (2).

There is an important debate about how much each dimension contributes to functionality of schizophrenia patients with the bulk of the data (3, 4, 5) suggesting that cognitive and negative symptoms decisively participate in long term functionality of schizophrenic patients. Both Kraepelin and Bleuler were aware that positive symptoms do not represent the core of schizophrenia. Of course treating positive symptoms still represents an important part of the management of schizophrenia, but by no means equals the most important part. During the acute phase of schizophrenia the patient may act in way which can be extremely deleterious for his social, professional or familial relationships not to mention direct threats of personal health or even life (i.e. during an acute exacerbation of symptoms one patient having command auditory hallucinations may act on them and kill himself etc., etc).

Reduction of positive symptoms has been therefore an important goal in schizophrenia therapy since the beginnings of drug treatment developments, despite the fact that very soon clinicians became painfully aware of the importance of treating negative and cognitive dimensions of schizophrenia (1). Schizophrenia is a heterogeneous clinical syndrome, including positive and negative features and neuropsychological impairment, also having impaired social and occupational functioning as a core characteristic.

Abstract:

Introduction: Schizophrenia represents a chronic and debilitating illness listed by the international organisms as top priority for public health actions to reduce disability and improve the function and quality of life for people living with chronic illness.

Objective: The aim of this study was to compare psychosocial functioning of schizophrenic patients after 1 year of neuroleptic treatment in a first episode schizophrenia population treated with atypical or typical antipsychotics.

Methods: Procedures of the European First Episode Schizophrenia Trial study (EUFEST) have been previously described. Data analyzed in this paper refers to Romanian patients (N = 113) included in the EUFEST study. Psychosocial functioning was assessed by Global Assessment of Functioning (GAF). GAF questionnaire was applied at baseline and at 1, 2, 3, 6, 9 and 12 months (end of study).

Results: Mean value at 1 year compared with baseline was 76.88 (±16.20) vs. 39.06 (±13.56) for Haloperidol, 75.58 (±18.41) vs. 40.67 (±12.71) for Olanzapine, 78.57 (±10.15) vs. 37.65 (±17.05) for Quetiapine, 82.35 (±10.16) vs. 38.24 (±12.52) for Amisulpride, 76.11 (±10.26) vs. 38.33 (±10.26) for Ziprasidone. Statistical comparison with ANOVA revealed no statistically significant differences, p = 0.533. The improvement in functionality in patients did not differ between antipsychotics from one evaluation to another. During the antipsychotic treatment, the psychosocial functioning of patients improved significantly more during the first 6 months, irrespective of treatment arms. After that, the improvement continued to develop, but at a slower pace.

Conclusions: Our study didn’t support the superiority of atypical neuroleptics versus classical ones regarding functionality in first episode schizophrenic patients. The improvement starts fast with both classes of drugs and the larger part of improvement in functionality took part during the first 3–6 months of treatment.

Key words: Antipsychotic, functionality, first episode schizophrenia

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Psychosocial Functioning In Schizophrenia – Results From Romanian Cohort Of Eufest Study

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symptoms, as key goals for a better functioning of the patients. Guidelines for treatment in schizophrenia recommend that primary treatment should be pharmacological, antipsychotics representing the mainstay of the treatment (6). Antipsychotics are currently classified into: first generation, conventional or 'typical' antipsychotics (FGAs), second generation 'atypical' antipsychotics (SGAs) (7). Both classes of antipsychotics are targeting positive symptoms in schizophrenia and are capable of inducing extrapyramidal symptoms (EPS), however, atypical antipsychotics have some evidences regarding efficacy on negative and cognitive symptoms (8), although the mean effect is recognized to be small (9, 10) and are known for inducing less EPS but instead are associated with an increased risk for metabolic syndrome (11).

Recent studies challenge (12,13), the initial optimism that atypical antipsychotics are indeed associated with an improvement in negative or cognitive symptoms despite the fact that are authors who consider that a superiority in functionality in the case of patients treated with atypical antipsychotics compared with patients treated with conventional antipsychotics appear after a longer time of treatment (14).

Future research should aim to determine the most feasible and valid measure of functional status in schizophrenia, as we set as a target for treatment functional recovery. Efficacy of antipsychotics has been quantified by complex analyses of scores in scales of symptoms reduction, like PANSS (15, 16), but also by all-cause treatment discontinuation - the EUFEST and CATIE studies (13, 17), and quality of life – the CUtLASS study (18).

The most important goal of antipsychotic treatment in psychotic diseases is functional recovery (19). Assessment of functional status might represent a better indicator of overall status of a certain schizophrenic patient than psychometric tests that assess symptoms. Psychosocial functioning is strongly correlated with cognition and negative symptoms, but these domains are currently poorly targeted by schizophrenia treatment. The development of atypical antipsychotics was considered a very important step in the treatment of schizophrenic patients and a great hope at that moment also for improving psychosocial functioning. Atypical antipsychotics were created and proved to have less EPS and sedation which could have made instrumental daily activities easier; also improvement on negative symptoms could have made the patient to regain interest and initiative.

However, the results of later studies weren't so optimistic. The latest data comparing typical and atypical neuroleptics in schizophrenia treatment didn't reveal important differences between the 2 classes of antipsychotics regarding efficacy in improving cognitive and negative symptoms (9, 13). Clinical trials mostly assess efficacy (reduction of symptoms), which is less easy extrapolated to real life. In order to clearly define benefits of antipsychotics in treatment of schizophrenia, a study should assess effectiveness or achievement of functional outcomes, since this could make the study more real-life oriented. There are still scarce data on effectiveness of schizophrenia treatments.

Most clinical trials have used for establishing efficacy of an antipsychotic and subsequent marketing have included a selected patient population, too few women and subjects with comorbid conditions, which may not be a good reflection of patients seen in everyday practice (20). In order to overcome these drawbacks, large project trials like CATIE, Cafe, SOHO, CUtLASS, EUFEST have been designed in a naturalistic manner, in order to assess also effectiveness of antipsychotics, which means efficacy plus tolerability (21).

EUFEST trial is one of the most valuable naturalistic studies which assess effectiveness of antipsychotics in recovery of functional status because it includes first episode and treatment naive patients. EUFEST study has used DSM IV axis V evaluation of functionality - the Global Assessment of Functioning (GAF) scale (22). Although in present, the DSM V is recommending use of WHODAS as a global measure of disability in psychiatric disorders, the use of GAF has been proven throughout a decade of studies a simple and reliable measure of functional status (23).

Attitudes towards schizophrenia treatment have changed in view of recent neurobehavioral and epidemiological researches, which are showing that action directed towards improving functional status can have a profound impact on its onset and outcome (24). By assessing and evaluating psychosocial functioning in schizophrenic patients, it may be possible to determine the clinical status of a patient under treatment with antipsychotics. To address this issues, we analyzed data from EUFEST study (Romanian patients) relating to functional status of patients with first episode schizophrenia after 1 year of antipsychotic treatment. We also compared the efficacy of treatment on functional outcome across classes of drugs, between atypical and typical antipsychotics.

METHODS

Data analyzed in our paper are drawn from European First Episode Schizophrenia Trial study (EUFEST). The purpose of EUFEST study (25) was to compare atypical antipsychotics (amisulpride 200–800 mg/d, olanzapine 5–20 mg/d, quetiapine 200–750 mg/d, ziprasidone 40–160 mg/d) with low doses of typical neuroleptics (haloperidol 1–4 mg/d) in terms of effectiveness. The measure for effectiveness in EUFEST is all-cause treatment discontinuation, defined as the time to discontinuation of the study drug to which patients were originally randomized. Investigators from 50 centers in Europe and Israel participated into this trial. Eligible patients were 18–40 years of age and met DSM-IV criteria for schizophrenia, schizoaffective disorder confirmed by the Mini International Neuropsychiatric Interview Plus. Inclusion criteria were: 18–40 years of age and DSM-IV criteria for schizophrenia, schizoaffective or schizoaffective disorder confirmed by the Mini International Neuropsychiatric Interview Plus, first episode of disease with no more than 2 years elapsed between the onset of positive symptoms and recruitment into the trial and previous use of antipsychotic drugs of less than 2 weeks during the preceding year and less than 6 weeks lifetime. The investigators invited eligible patients to participate
providing information orally and in writing about the trial. After complete description of the study to the subjects, written informed consent was obtained. The trial complied with the Declaration of Helsinki and was approved by the Ethics Committees of the participating centres. Patients did not meet exclusion criteria in this study if: no more than 2 years elapsed since the onset of positive symptoms; any antipsychotic have not been used exceeding 2 weeks in the previous year or 6 weeks lifetime; patients had not a known intolerance to one of the study drugs; and patients didn’t meet any of the contraindications for any of the study drugs as mentioned in the (local) package insert texts. Baseline data were obtained between 4 weeks before and 1 week after randomization on demographics, diagnoses, current medication, psychopathology (Positive and Negative Syndrome Scale - PANSS), severity of illness (clinical global impression - CGI), overall psychosocial functioning (global assessment of functioning scale - GAF), extrapyramidal symptoms (St Hans rating scale - SHRS), depression (Calgary Depression Schizophrenia Scale - CDSS), neurocognitive performance (six measures: Trail Making A [time], Flexibility Index [Trail Making B–A time], Wechsler Adult Intelligence Scale Digit-symbol Coding [total correct], Purdue pegboard [total pegs with dominant hand], Rey Auditory Verbal Learning Test – learning index [total correct on trials I–V], and Rey Auditory Verbal Learning Test – secondary memory [total correct on Delayed Recall trial]), and quality of life (Manchester Short Assessment of Quality of Life - MANSA).

All scales have been given to the included patients at Baseline, 1, 2, 3, 6, 9, and 12 months. Data about quality of life were evaluated at baseline, month 3 and end of study (month 12).

In this article we used the term 'schizophrenia' for diagnostics of schizophrenia, schizophreniform and schizoaffective disorder.

Data analyzed in my paper refer to Romanians patients (N=113) included in this study.

**STATISTICAL ANALYSIS**

We used descriptive analysis to characterize demographics and repartition into treatment arms. Mean, SD, and sample size are provided for continuous variables. Discrete variables are described using frequencies and percentages. All statistical tests were 2 tailed; α (level of significance) was 5%. Discrete variables were analyzed with a χ2 test. The differences between different treatment arms (Haloperidol, Olanzapine, Amisulpride, Quetiapine, Ziprasidone) were assessed using ANOVA function and corrected with Bonferonni t-tests. Within-group improvement in GAF scores over time was evaluated using paired-sample t-tests. Concerning cognitive functioning, for simplicity a composite score of cognitive functioning was created, after standardizing to create z scores and obtaining the mean for standardized values on the neurocognitive tests. Data were analysed using Statistical Package for Social Sciences (SPSS) version 16.

**RESULTS**

The EUFEST study in Romania included 113 patients which were randomized to one of the treatment arms. From the 113 initial randomized, 61 (54%) are women and 52 (46%) men.

GAF scale was applied by clinicians at baseline, 1, 2, 3, 6, 9, and 12 month (end of study).

Of the 113 patients in Romanian cohort of EUFEST study, 2 patients did not have valid baseline data and 20 patients did not complete the study. We analysed socio-demographical and clinical characteristics differences between completers and non-completers, because people who didn't finish the study might be different (and therefore could reduce the reliability of results) from people who completed the study. We found that non-completers were more frequently (significantly statistic) having an occupation and reported a better Quality of Life (significantly statistic) comparing with completers, without any other differences. Data are presented in table 1.

<table>
<thead>
<tr>
<th></th>
<th>Completers</th>
<th>Non-completers</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong> (years) a</td>
<td>27.12 (+/-6.11)</td>
<td>25.91 (+/-5.86)</td>
<td>.419</td>
</tr>
<tr>
<td><strong>Education (in years)</strong> a</td>
<td>12.33 (+/-2.68)</td>
<td>12.95 (+/-3.00)</td>
<td>.363</td>
</tr>
<tr>
<td><strong>Gender</strong> b</td>
<td>52.7% women</td>
<td>60.0% women</td>
<td>.626</td>
</tr>
<tr>
<td><strong>Married (yes)</strong> b</td>
<td>21.5%</td>
<td>15.0%</td>
<td>.760</td>
</tr>
<tr>
<td><strong>Having an occupation (yes)</strong> b</td>
<td>48.4%</td>
<td>75.0%</td>
<td>.047</td>
</tr>
<tr>
<td><strong>Composite cognitive score baseline</strong> a</td>
<td>-.02 (+/- .51)</td>
<td>.08 (+/- .39)</td>
<td>.463</td>
</tr>
<tr>
<td><strong>Functionality (GAF baseline)</strong> a</td>
<td>39.83 (+/-12.87)</td>
<td>34.37 (+/-12.35)</td>
<td>.093</td>
</tr>
<tr>
<td><strong>Quality of Life (MANSA baseline)</strong> a</td>
<td>3.90 (+/- .99)</td>
<td>4.65 (+/- .80)</td>
<td>.002</td>
</tr>
<tr>
<td><strong>PANSS total score (baseline)</strong> a</td>
<td>90.25 (+/-19.71)</td>
<td>88.65 (+/-9.82)</td>
<td>.725</td>
</tr>
<tr>
<td><strong>PANSS positive subscale (baseline)</strong> a</td>
<td>25.28 (+/-6.02)</td>
<td>24.95 (+/-5.89)</td>
<td>.822</td>
</tr>
<tr>
<td><strong>PANSS negative subscale (baseline)</strong> a</td>
<td>20.50 (+/-7.50)</td>
<td>20.40 (+/-6.44)</td>
<td>.956</td>
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<tr>
<td><strong>PANSS general psychopathology subscale (baseline)</strong> a</td>
<td>44.47 (+/-10.71)</td>
<td>43.30 (+/-6.09)</td>
<td>.639</td>
</tr>
<tr>
<td><strong>Depression (CDSS, baseline)</strong> a</td>
<td>5.02 (+/-5.83)</td>
<td>3.21 (+/-4.14)</td>
<td>.201</td>
</tr>
</tbody>
</table>

*Statistic = t-test  
*Statistic = chi-square test

Table 1. Socio-demographical and clinical characteristics of completers vs non-completers in EUFEST study – Romanian cohort

There are no differences regarding treatment arm allocation between groups as evaluated by logistic regression (p= .432).

A summary of data upon socio-demographics and clinical characteristics (PANSS total score) across treatment arms

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in the population analysed in this study revealed no baseline differences (Table 2a and 2b).

![Table 2](image)

Data about GAF scores during the study by treatment arms are presented in table 3. There was no overall difference between the five treatment groups in GAF scores between baseline and end of study time ($F=7.93, df=4, p=0.533$) or in-between visits (all $p$ values $>0.05$).

Change in GAF score from baseline to end of study (12 months) showed improvement in each of the five treatment groups (Paired t-tests: haloperidol: $t=-8.388$, $df=16$, $p<0.001$; olanzapine: $t=-8.403$, $df=23$, $p<0.001$; quetiapine: $t=-7.128$, $df=12$, $p<0.001$; amisulpride: $t=-13.974$, $df=19$, $p<0.001$; ziprasidone: $t=-11.560$, $df=17$, $p<0.001$).

Analysis of variance (ANOVA $F$, $dF$, $p$-values between classes$^4$)

Table 3. GAF scores across treatment arms in EUFEST study – Romanian cohort

The improvement in functionality in patients is presented in graph 1. We did not note any differences between treatment arms regarding functionality in patients at the moment of inclusion in study. No significant differences between treatment arms regarding functionality occurred at any following evaluation ($p>0.05$ at month 1, 2, 3, 6, 9, and 12). Controlling for multiple comparisons using Bonferroni corrections $t$ tests comparing the change in GAF score from baseline to each of the visits for haloperidol versus the other four treatment arms of second-generation antipsychotic drugs (Olanzapine, Amisulpride, Quetiapine and Ziprasidone) did not reveal any significant differences. Moreover, there are no differences in functionality between atypical antipsychotics.

During the treatment, the functionality of patients greatly improved during the first 6 months irrespective of treatment arms, as it can be seen on the graphic 1 and table 4. The improvement in functionality had occurred faster in the first 3 months of treatment irrespective of treatment arm. After that, the improvement continued to develop but in slower pace.
It would be interesting to observe if this trend continues over longer time because, if this would be the case, psychosocial functioning improvement in the first 3-6 months may represent a good predictor of long term treatment in schizophrenia. If longer studies confirm this trend, a clinical decision about which neuroleptic to use for long term may be improved by information of such type.

One limitation of our study is that data are obtained about first episode schizophrenic patients. In this kind of patients, the clinical response and consequently the functionality is larger than in chronic schizophrenic patients (26, 27). Other limitation is the relatively short duration of treatment (1 year). Longer studies would be more informative regarding long term functional outcome in patients treated with older versus newer antipsychotics. Functionality of a schizophrenic patient depends on multiple characteristics mainly (but not limited at) premorbid functioning, cognitive functioning, psychopathology and so on. The results of our study suggest several observations:

1. Our study didn’t support the superiority of atypical neuroleptics versus classical ones regarding functionality, which may represent a larger and better suited item for clinical evolution. There is a lot of research done to prove differences between older (typical neuroleptics) and recent neuroleptics. The discussion about putative superiority of atypical neuroleptics versus the typical ones dates already for a decade (9). Recent data about clinical advantage of atypical vs typical neuroleptic seem to indicate that there are no important differences between the 2 classes (28, 29). However, longer studies are needed to validate or refute these observations.

2. The bulk of improvement of functionality in first episode schizophrenic patients appeared during the first 6 months, afterward the improvement continues, but on a slower pace. Moreover, from the initial greater improvement (6 months) the greatest improvement took part during the first 3 months.

3. One limitation of our study is the fact that data are obtained about first episode schizophrenic patients. In this kind of patients, the clinical response and consequently the functionality is larger than in chronic schizophrenic patients (26, 27). Other limitation is the relatively short duration of treatment (1 year). Longer studies would be more informative regarding long term functionality in patients treated with older versus newer antipsychotics.

CONCLUSIONS

In first episode schizophrenic patients we did not found statistically significant differences regarding functionality after 1 year of treatment between typical neuroleptics and atypical neuroleptics (without differences at 1, 2, 3, 6, 9 and 12 months). The improvement starts fast with both classes of drugs and the larger part of improvement in functionality took part during the first 3-6 months of treatment. The assessment of functionality in first episode patient should be used in studies with longer duration in order to investigate which antipsychotic is best for long term use.
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DEPRESSION IN YOUNG ADULTS WITH CHRONIC SOMATIC ILLNESS – AN ANALYSIS OF 1970 BRITISH COHORT STUDY

Alexandra I. Mihaiësco, Valentin P. Matei, Liliana V. Diaconescu, Ruxandra Al-Bataineh, Traian Purnichi

Abstract
The prevalence rate of depression occurring in people with somatic illnesses is 3 times more than people without somatic illnesses, but less research was conducted in this respect for people with early onset of somatic disease. Taking into account that the presence of depression in chronic patients aggravates the somatic disease, leading to a poor prognosis and higher rates of mortality it is important to detect and treat it.

The purposes of our study are to analyse in a large cohort (BCS-70) the risk of depression in patients with somatic illness at early ages (less or equal 30 years).

Methods
Data used in our paper were drawn from the 1970 British Cohort Study (BCS70). The design and conduct of this study have been described elsewhere (1). Data for the present paper are drawn from 30 years wave. The data were analysed with descriptive function, chi-square and logistic regression. All analyses were performed using SPSS 16.

Results
At age 30, we have found 1409 people (12.7%) with depression. From a total of 11211 people there are 860 people with hypertension (7.7%) and 109 people with diabetes (1%). There is an increased risk of depression in the case of people with „pure” hypertension or „pure” diabetes (p<0.05). In the case of people with both hypertension and diabetes, logistic regression showed that hypertension is a risk factor for depression irrespective of socio-economic status and diabetes (Exp(B)=1.970, CI=1.579-2.458, p=.001).

Conclusion
The above data indicate that risk of depression is higher in people with onset before 30 years old of hypertension and/or diabetes. Our study did not identify an increased risk for depression by socio-economic class.

Data of our study clearly suggests that it is extremely important that young patients with somatic diseases like diabetes and/or hypertension should be aggressively screened and treated for depression.

Key words: depression, chronic somatic illness, young adult, diabetes, hypertension

Introduction
Depression represents a major cause of morbidity and mortality (1). The prevalence of depression is increasing (2) and by 2012 it is reported to be among the first 10 diseases causing loss of years due to disability (3). Depression is responsible for the greatest proportion of burden associated with non-fatal health outcomes accounting for approximately 10% total years lived with disability(4), more than cardiovascular disorders (2.8%), diabetes (3.0%), or chronic respiratory diseases (6.3%)(3). Chronic somatic illnesses are the cause of significant burden on individuals, families, societies and countries. Chronic somatic diseases that are frequent in the age group 18-44 years old are cardiovascular disease (most frequent hypertension – reported frequencies between 1.4%(5) and 8.7% (6)), cancer (aprox 2% prevalence (7)), diabetes (reported frequencies 1.4%(5) to 2.6%(8)) and respiratory diseases (aprox 4%(5)).

The most frequent chronic medical conditions associated with depression are: heart disease(9,10), hypertension(11), diabetes (12,13), asthma (14). The prevalence rates of depression occurring in people with somatic illnesses is two (15) to three (16) times more than people without somatic illnesses. In patients with two or more chronic medical conditions the risk of depression is six times higher comparing with healthy persons(17).

Many studies focused on co-morbidity of depression with one single chronic condition. Researchers found a high prevalence of depression in people with diabetes, its rates varying by diabetes type and among developed and developing nations (18). The prevalence of depression in diabetes patients may range between 2 and almost 30%
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(19-23), with higher values found in patients with type 2 diabetes (24,12) and among females with diabetes (25). Prevalence in diabetic group age 18-44 years old is less than 5% (8). Young adults with diabetes face difficulties with diabetes self-management and co-morbidity of depression is deteriorating even more diabetes adaptation (26,27).

The burden of comorbidity
Morbidly and mortality in patients with somatic illnesses and depression are significantly higher than in patients with somatic illness who are not depressed. These patients face many negative health consequences: they present more severe somatic symptoms and complications (28), have poor outcomes of somatic disease and more functional disability (29), a lower quality of life (30,31), a low treatment adherence (32,33), an increased use of medical services (34,35) and higher health care costs (36,38). Co-morbid depression among patients with diabetes is associated with poor diabetes outcomes (such as glycaemic control), with more and greater complications (such as diabetic retinopathy, nephropathy, neuropathy) with functional disability (39–41), with a lower quality of life (23), with a decreased adherence (35) and with higher healthcare costs (42).

Another relevant example is the link between hypertension and depression. Clinical studies show that depression is common in patients with hypertension, has a certain influence in blood pressure control and a significant impact on severity of hypertension (43,44). Depressive symptoms have been found to be predictive of hypertension in young adults (45). The association between cardiovascular illness and depression has multiple biological and clinical links and is likely bidirectional. Most cited pathophysiological mechanisms are hormonal variations, metabolic abnormalities, hypercoagulability, increased platelet aggregation, inflammation, and endothelial dysfunction (46,47). Depression is most likely aggravating the associated cardiovascular disease by impeding the optimal care for this people.

The importance of depression detection.
Although depression has a high prevalence and it is present in patients with chronic somatic illnesses, depression among these patients remains often undetected (19,37). Although depression is highly prevalent in individuals with multimorbidity, studies on the rates and correlates of depression in these individuals are scarce (48).

People aged less than 30 have a prevalence of somatic illness less than 10%, however, a chronic disease that begins early will result in a worse overall prognosis of the person affected (49). In this respect, our study is attempting to study if there is an increased risk for depression for people with two frequent somatic illnesses, hypertension and diabetes at age 30. Because the association between these two illnesses is quite common, we looked at the increasing or risk for depression not only in pure diabetes and hypertensive groups but also in increasing the risk for depression in comorbid group (i.e. hypertension and diabetes). Methods

Data used in our paper were drawn from the 1970 British Cohort Study (BCS70). The 1970 British Cohort Study (BCS70) is a cohort study that enrolled 16,567 babies born in England, Scotland, and Wales on 5-11 April 1970 (50,51). The original study focused on children health and has successively expanded to examine physical, educational and social development of these children. Individuals participating in this cohort study were assessed at birth with a 96.7% response rate and in ongoing follow-ups using a multi-method, multi informant approach. Participants were followed up at 5 (n = 13 135, in 1970), 10 (n = 14 875 in), 16 (n = 11 622 in 1986), 26 (n = 9003, in 1996), 30 (n = 11 261 in 2000) and 34 (n = 9656, in 2004) years of age.

At 30 years, marked efforts were made to recruit difficult-to-reach subjects (51). Data for the present paper are drawn from 30 years wave (52).

Measure of depression. At age 30, data was collected on the severity of depressive symptoms using The Malaise Inventory. An overall Malaise score for a cohort member is the sum across the individual variables, yielding a minimum score of 0 and a maximum of 24. A score of 8 or higher is a recommended cut-off for a depressive episode (53).

Measure of hypertension and diabetes. Data about somatic illnesses were obtained from patients. At age 30 people from cohort were asked: “Have you ever had or been told you had high blood pressure?”. “Have you ever had diabetes?” They could respond with “yes”, “no”, “don’t know” and “not answered”. We excluded from the analysis the last 2 groups of responders.

Measure for socio-economic status. Data about social class of people from cohort were used as proxy for socio-economic status (ses). Social classes were defined as such: “Professional”, “Managerial-technical”, “Skilled non-manual”, “Skilled manual”, “Partly skilled” and “Unskilled”.

Statistical analyses. We created 2 groups, the first one comprised of people considered controls (overall Malaise score less or equal 7), the second one assumed to have depression (Malaise score of 8 or over). The data were afterward analysed with descriptive function, chi-square and logistic regression. All analyses were performed using SPSS 16.

Results.

Descriptive data. From a total of 11211 people there are 860 people with hypertension (7.7%) and 109 people with diabetes (1%). From a total of 11211 people 1409 (12.6%) have depression, and from this, 193 have developed hypertension (high blood pressure) and 27 have developed also diabetes, as it is shown in the figure below.

Figure 1. Distribution of hypertension, diabetes and depression within the BCL-70 cohort
Data were first analysed with chi square. The proportion of people with depression in the hypertension group is higher 21.5% (183 out of 852) than the proportion of depression in non-hypertensive group 11.9% (1225 out of 10256), OR = 2.017, CI=1.694-2.400, p=.001. The proportion of people with depression in the diabetes group is also higher 24.8% (27 out of 109) than the proportion of depression in non-diabetes group 12.6 % (1382 out of 11003), OR=2.922, CI=1.478-3.554, p=.001.

**Socio-economic status.** It is virtually impossible to evaluate the causality in a cross-sectional study like this wave of the cohort. However, due to the fact that socio-economic status may influence hypertension, diabetes and depression, we analysed data to see this putative influence. Our analysis showed that socio-economic status did influence hypertension (Exp(B)=.879 CI=.797- .969, p=.009), depression (Exp(B)=1.288, CI=1.118-1.398, p=.001) but not diabetes (Exp(B)=1.081, CI=.811-1.440, p=.597).

Moreover, there is also possible that people with hypertension may be at risk for diabetes, and therefore we analysed data (chi square) and indeed, people with hypertension have a higher proportion of diabetes 3.7% (32 out of 860) compared with people with diabetes but without hypertension 7% (77 out 10347), (OR 5.155, CI=3.393-7.832, p=.001).

Because the possible influences between variables are intricate (socio-economic status may influence somatic illnesses but also depression, somatic illnesses may increase depression risk and depression may increase risk for somatic illnesses or decrease socio-economic status and somatic illnesses may increase the risk for the other somatic illness) we decided to analyse all the data with logistic regression using depression as dependent variable and hypertension and diabetes as independent variable, while controlling for socio-economic status. In this model depression risk is increased by hypertension (Exp(B)=1.970, CI=1.579-2.458, p=.001) and socio-economic status (Exp (B)=1.280, CI=1.180-1.389, p=.001) but it is not increased by diabetes (Exp(B)=1.623, CI=.859-3.065, p=.135).

The above data seem to indicate that hypertension is a risk factor for depression irrespective of socio-economic status and diabetes. However, when we analysed data only for people with diabetes but without hypertension (chi square, without controlling for socio-economic status because we already seen from previous presented analyses that socio-economic status didn't influence diabetes risk) it appeared that diabetes also increased risk for depression, 21.1% from diabetes group (17 out 77) and 11.9% (1208 out of 10179) from healthy people, p<0.05 (see table below).

We looked for risk of hypertension but without diabetes, while controlling for socio-economic status (because socio-economic status did influence, as seen from previous analyses hypertension and depression risk). There is an increased risk for depression in "pure" hypertension group (hypertension without diabetes), p<0.05 (see table below). We are also looking in group comprised of people with hypertension and diabetes while controlling for socio-economic status and there again it is an increased risk comparing with normal group, p<0.05 (see table below).

Data resulting from logistic regression are shown in the table below.

<table>
<thead>
<tr>
<th>Risk for depression in BCS70</th>
</tr>
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<tbody>
<tr>
<td>High blood pressure</td>
</tr>
<tr>
<td>Diabetes</td>
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<tr>
<td>High blood pressure and diabetes</td>
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Table1. Risk for depression in the chronic illness groups formed in BCS70 cohort

**Discussion**

Our study supports that both diabetes and hypertension increased depression risk, which replicates results from previous studies –(24,13,19,48,45,5456). We would have preferred to have more objective data about the presence chronic somatic illnesses at 30 years adults. However, the only questions from the cohort which could have offered more objective data “Subject seen a doctor for high Blood Pressure in past 12 months?” and “Subject seen a doctor for diabetes in past 12 months?” come with huge numbers of missing questions (10914 for the first one and 11178 for the second one leaving to few subjects to be analysed 295 for hypertension and 78 for diabetes) and no control group, therefore impossible to analysed. The lack of more objective information regarding somatic illnesses represents one important weakness of our study.

However, strength of our study is that it looked into the association between the 2 illnesses, which is rather rare in this kind of study. Results of our study suggest that the risk is a little bit higher in co-morbid group, but the augmentation of this risk is not quite significant. Moreover, our study controlled the data for socio-economic status, which is rare in this kind of study.

One more important observation is the fact that people included in analysis are young, while other studies of this kind looked in rather older population (49,57,58). The young age of onset of chronic illness indicates that they may be predisposed to more severe evolution. The pervasive impact of depression on quality of life and its potential negative effect on chronic disease management warrant aggressive screening and clinical interventions appropriate to each country’s healthcare system in young adults with diabetes and/or hypertension.

**References**

Depression In Young Adults With Chronic Somatic Illness – An Analysis Of 1970 British Cohort Study

Alexandra I. Mihailescu; Valentin P. Matei; Liliana V. Diaconescu, Roxundra Al-bataineh, Md. Traian Purnich: Depression In Young Adults With Chronic Somatic Illness – An Analysis Of 1970 British Cohort Study


RESISTANT PSYCHOSIS IN A PATIENT WITH COEXISTING BETA-THALASSEMIA AND LATENT TOXOPLASMOSES

Alexandra Barbilian¹, Dan Prelipceanu²

Abstract
We present the case of a 44 year-old caucasian male (V.B) with a known psychiatric history of paranoid schizophrenia, admitted to "Prof. Dr. Al. Obregia" Clinical Hospital of Psychiatry during the months of May-July 2015 (67 days of hospitalization) for: compound and complex auditory and visual hallucinations, paranoid delusions, hallucinatory behavior, psychotic anxiety and sleep disturbances, symptoms which had intensified in the several months preceding admission despite following adequate antipsychotic treatment. We present the difficulties we encountered in treating his resistant psychosis, the process of diagnosing his co-morbidities (beta-thalassemia and latent Toxoplasma gondii infection), a differential diagnosis of the intense positive symptoms the patient presented and the implications of toxoplasmosis in the evolution and treatment of a paranoid schizophrenic patient.

Conclusion.
The scope of this paper was to show the importance of performing a differential diagnosis and a thorough work-up however certain we are of the patient's initial presentation. We also wanted to emphasize the need for studies that present more effective treatments of resistant psychosis with fewer adverse reactions. The etiology of schizophrenia presents a tremendous challenge for both researchers and physicians, the latent toxoplasmosis infection observed in high prevalence among schizophrenic patients representing only a small part of what remains to be discovered. Ultimately we must draw attention to the importance of a multidisciplinary approach to every case encountered.

Key words: resistant schizophrenia, Toxoplasma gondii, Cooley's anemia, complex hallucinations

BACKGROUND
Treatment resistant schizophrenia represents a challenge for any psychiatrist, especially if the patient presents other co-morbidities like Cooley's anemia and latent toxoplasmosis infection and a long course of evolution as is the case presented in this article. The issue of performing a well-documented differential diagnosis remains equally important to a chronic patient with a long psychiatric history and an apparently solid diagnosis of paranoid schizophrenia as it is in the case of an acute de novo psychotic episode. Research over the past years has shown a high prevalence of Toxoplasmosis infection in patients with neuropsychiatric symptoms and disorders, most prominently in paranoid schizophrenia and mood disorders, with influences on the course, severity, treatment approach and response. [17,18,19,20,21]

We present the case of a 44 year-old caucasian male (V.B) with a known psychiatric history of paranoid schizophrenia, admitted to “Prof. Dr. Al. Obregia" Clinical Hospital of Psychiatry during the months of May-July 2015 (67 days of hospitalization) for: compound and complex auditory and visual hallucinations, paranoid delusions, hallucinatory behavior, psychotic anxiety and sleep disturbances, symptoms which had intensified in the several months preceding admission despite following treatment with clozapine 300mg/day and fluphenixol decanoate depot 20mg/21days.

PAST PSYCHIATRIC HISTORY
The patient was first diagnosed with schizophrenia in 1991 at 21 years old, shortly after finishing national service. While in his military service, the patient recalls presenting social withdrawal, flattened affect and a decrease in volition, symptoms that caught the attention of the unit's physician. Positive symptoms (auditory and visual hallucinations and delusions) were already present at his first psychiatric admission. In the following years after receiving the diagnosis, he had other 3 admissions in the psychiatric ward, in 1996, '98 and '99, after which his evolution was monitored in a non-hospital setting. Over the years, the patient underwent treatment with a wide range of antipsychotics (thioproperazine, olanzapine, risperidone etc.) but responded only partially, both positive and negative symptoms remaining present. In January 2015, while being treated with clozapine 500 mg/day, levomepromazine and alprazolam, he experienced a loss of consciousness accompanied by tonic-clonic seizures and post-critical confusion and was admitted to the local neurology emergency unit. His evolution was favorable under treatment with antiepileptic agents and a decrease in clozapine dosage. He was discharged with the diagnosis of G.40: localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable. Following this episode the patient's positive symptoms worsened, the hallucinations becoming more prominent accompanied by hallucinatory behavior which eventually led to the admission to our ward.

The patient was never married, has no children,
Alexandra Barbilian, Dan Prelipceanu: Resistant Psychosis In A Patient With Coexisting Beta-thalassemia And Lantent Toxoplasmosis

was never employed and keeps a very close relationship with his sister who is also his caregiver. The patient doesn't use nicotine or alcohol and has no relevant family psychiatric history. From his family medical history we know that his father dyed from metastatic lung cancer. He denies having any allergies, is myopic and his medical history involved two right humeral fractures and one right scapular fracture, treated surgically in 2014 which the patient recounts occurred “when I was practicing boxing and when I jumped off a table...I was training” and an uninvestigated chronic anemia which was treated with iron supplements.

PSYCHIATRIC EXAMINATION performed on 19.05.2015: The patient appears to be his stated age, his overall appearance is slightly disheveled although dressed appropriately, wearing a suit and eye glasses, with adequate hygiene and grooming. He exhibits slight distress and anxiousness, seems uneasy but is cooperative. Motor activity appears to be in normal limits although he displays generalized jitteriness and restlessness. His speech lacks in spontaneity, is slow and halting, quiet, anxious and presents a slight stutter. There aren't significant abnormalities in his thought process, his answers are appropriate, most of the times to the point, at times circumstantial. The patient is very polite, almost manneristically so. The patient's thought content is pathological, marked by persecutory and grandiose delusions “These people I see are out to get me, they're in combat with me, they won't let me live.” “I have been chosen by them, I'm the only one they can communicate with.” Perceptual disturbances are the prominent symptoms in this patient. He describes ego-dystonic compound hallucinations, both auditory: voices of people, “many of them, men and women”, which commentate his actions, talk to him and are most of the times imperative; and visual hallucinations which are well-formed, complex, include numerous people, animals and objects “there are thousands of them, men and women, a whole world” “They are constantly looking at me” He also describes scenic hallucinations “I see the other world, of those who are gone, I see where they are, what they're doing, I see people right in this room, they're looking at us.” He perceives the audiovisual hallucinations as being constant during the day while also interacting with “the other world” and the people in it in his dreams. The patient relates that the hallucinations had always “been there”, he admits to perceiving them during the past years, but that only in the last few months the voices had become imperative “My father is dead, he had glaucoma. They urge me to take out my eye, my left eye and give it to him to eat. In the last couple of months I have started to do what they're asking, I'm trying to find a way to take it out, I don't want to do it, but they're making me.” He describes his mood as being anxious “I'm frightened about what the voices are saying and making me do.” The quality of his affect is congruent with his mood and thought content, he exhibits moderate anxiety and a restricted range of emotions, both facial expression and voice lack spontaneity. In contrast to the patient's cognitive abilities (a score of 28 on MMSE with abstract reasoning within normal ranges and a well-developed vocabulary) he has a low level of functioning, an inability to hold a job or even day-to-day chores “I can't concentrate enough, I hear them and I see them, I would love to read novels, but I can't, they take over my mind.” The patient's judgment is fair, he understands the consequences of his actions and is able to distinguish right from wrong, but fails to follow his judgment and seems to be struggling with what the voices command him to do: “I know it will hurt, I know I shouldn't do anything to hurt myself but I can't help but try to do what they're asking in order for them to stop... They won't stop unless I do what they say and take out my eye”. The patient is able to test reality, but questions his own insight and admits that “I know I'm ill and that's why I see and hear the things I do, but they are so real that I can't but help to believe they're real and try to act on what they're telling me.”

PHYSICAL EXAMINATION revealed diaphoresis, pallor and tachycardia (110 bpm regular) while the neurological examination was unremarkable apart from a generalized tremor.

LABORATORY AND IMAGING TESTS
We reviewed the laboratory findings taken during his admission at the neurology unit in January which revealed a microcyclic/hypochromic anemia (RBC 5.82 million cells/ml, HGB 11.5 g/dl, HCT 37.4%, MCV 64.3fl, MCH 19.8pg) with low serum iron (53ug/dl) - which the patient told had been treated with iron supplements and leukocytosis (WBC 13.5 k/μl)68.9ug/dl. In the follow-up CBC and iron studies the RBC indices were even lower (HGB 9.9g/dl, HCT 30.9%, MCV 60.2fl, MCH 19.3pg) with a serum iron level of 116ug/dl. A hemoglobin electrophoresis test was done which confirmed the diagnosis of beta-thalassemia minor (Hb A2 5.7%, Hb A 93.6%, Hb F 0.7%). At the time of admission to our ward the patient's WBC was 10.05 k/μl which we attributed to the long-term treatment with clozapine.12 CK, within normal range (42 UI). Native CT was normal apart from a modest bi-frontal cortical atrophy. EEG was unremarkable.

COURSE AND TREATMENT
The patient was admitted on 19° May. During the first two days of admission we continued the patient's treatment with clozapine 300mg/day to which we added levo-nemprazine 50mg/day. The patient's hallucinations were present, even heightened in their commanding effect “They tell me that my father's glaucoma extended to his other eye, now I have to take out both of my eyes. Last night, I couldn't sleep, they wouldn't let me, I tried to find a gap, a breach so that I could take my eye out” The patient also accused nightmares with similar content to that of his hallucinations. At the recommendation of the hospital's GP the patient also started treatment with folic acid and vitamins for the recently diagnosed beta-thalassemia. Over the next days, haloperidol (15-20mg/day) and trihexyphenidyl (4mg/day) – the patient presented geniospams- were added to his treatment regimen with no effect on the patient's perceptual disturbances. During the evening of 29° May, the emergency psychiatric unit was called because the patient was intensely psychotic, anxious, asking the medical staff to “please, tie me up, they're telling me to take out my eye, I'm afraid I'll hurt myself or someone else, they're stalking me”. At the patient's repetitive requests he was physically restrained for a total duration of an hour and administered 10mg diazepam, 200mg Leporex and 25mg levomepromazine. From the 2° of June his treatment was changed to Leporex 300mg/day, amisulpride (500mg/day) and diazepam...
After two weeks the dosage of amisulpride was increased, first to 800mg/day and later to 1000mg/day which was continued for almost two weeks. The patient's complaints continued and so did his psychotic anxiety as the hallucinations persisted. There were only a few days in which he reported the voices were less imperative “They don't seem to tell me to take out my eye so much”, but for the whole duration of his hospitalization the positive symptoms were resistant to treatment. With the signed consent of the patient and his caregiver, on the 25th and 29th of June he underwent two ECT sessions and on the 1st of July was subjected to the third. Not only did the ECT have no result on the patient's symptoms but the last ECT session resulted in the patient suffering a left scapular fracture for which he received orthopedic treatment and pain relief medication. We had to stop the ECT treatment. The patient continued having the same type of compound audio-visual hallucinations which he described vividly: “I can see their world and our world at the same time, I can also travel to their world, walk among them, infiltrate their group. I can see them now, they're standing where they always stand, thousands of them standing side by side on a spiral, a descending tower in the form of a spiral, they are watching us now. There are men, women, children, even animals.” The patient's positive symptoms also consisted of delusions of grandeur and disorganized thought content: “I was a tree in Belarus in another life, a saint planted me there. I'm still holding onto the branches lest I fall. I fear I'll break my bones if I do.” “The voices are talking about religion, I can see God with my mind's eye, he is talking to the mortals.” “They tell me I'm not my mother's son, that she was fertilized and I'm the son of another woman, whom I've met in 2002 among the people I see from the other dimension.” On the 16th of July the medical team decided to perform an indirect ELISA Toxoplasma gondii antibody detection test which showed a high level of IgG Toxoplasma antibodies (955.627 UI/ml). Over the rest of the hospitalization the patient received clozapine 150mg/day, aripiprazole 30mg/day and sodium valproate 1000mg/day with the positive symptoms remaining stable and not so imperative “I can see and hear them like I've always had but they've stopped telling me to take out my eye, they're talking among themselves about religion, they say I've hidden from them and they want revenge”. We continued the treatment for the rest of his hospitalization, the patient continued to present the same perceptual disturbances but they gradually became less commanding. He was discharged stable with the following treatment: Lepoxen 150mg/day, Abilify 30mg/day, Orfirit 1000mg/day and folic acid with the recommendation of a parasitological exam. So far the patient has followed the same prescribed treatment, didn't follow up with the parasitological evaluation and continued exhibiting the same chronic persecutory features but managing to “keep the voices under control.”

DISCUSSION: There are many notable features about this case. Firstly we are dealing with a case of chronic unremitting psychosis which remained resistant to treatment with clozapine augmented by other antipsychotic agents. One of our approaches after the combination of haloperidol with clozapine proved to be ineffective was to augment the patient's clozapine treatment with amisulpride, an antipsychotic found to be effective in patients with resistant psychosis.(5,6) The association brought no significant benefit to our patient. A second approach was ECT-augmented clozapine therapy. A 2016 meta-analysis concluded that ECT-augmented clozapine treatment may be both effective and a safe alternative to treatment of resistant psychosis. The same study suggests that a higher than usual number of ECT treatments may be necessary.(1) Regrettably, we were unable to perform more than three, due to the scapular fracture the patient suffered during his last ECT treatment. We attributed this event to the patient's beta-thalassemia co-morbidity in which extra-medullary hematopoiesis, bone frailty and consequent fractures are common findings (2, 3, 4) Moreover, an interesting aspect both Cooley's anemia and schizophrenia seem to be genetically linked with abnormalities found on chromosome 11.(16) Yet another attempt was adding aripiprazole and sodium valproate to the existing clozapine treatment taking into account studies which suggest an improvement in efficacy.(7,8,9,10) This choice of treatment combined with the addition of sodium valproate to clozapine proved to be somewhat successful in relieving the patient's psychotic anxiety and disordered thoughts although faintly. The intensity of his positive symptoms. The second prominent feature of the case is the differential diagnosis of the patient's chronic psychosis. What we found remarkable was the high discrepancy between the patient's cognitive level of functioning and the strength and vividness of his perceptual disturbances which, together with the resistant character of the exhibited pathology, at times made us question the diagnosis. We considered other known causes (13) of complex hallucinations as temporal epilepsy and Lhermitte's peduncular hallucinosis. The diagnosis of epilepsy was dismissed, the patient having a normal EEG and no past history of epileptic seizures apart from the above mentioned episode, occurred in January, considered to be a side-effect of the chronic clozapine treatment which is reported to increase the risk of seizures up to 6%, with certain studies suggesting seizure prophylaxis in patients undergoing treatment with clozapine following the first seizure occurrence.(14,15) The diagnosis of peduncular hallucinosis was discarded given the patient's long psychiatric history and his recount of what seemed to be the prodromal phase of his schizophrenia. Lastly, our team was very intrigued at finding a clear confirmation of a latent Toxoplasma gondii infection. Latent infection with this parasite has, in recent years, been repeatedly incriminated in the development of certain neuropsychiatric symptoms such as anxiety, agitation, mood fluctuations, paranoid psychosis and even specific disorders such as schizophrenia and depression.(17,18,19,20,21) Toxoplasmosis has a high prevalence among schizophrenic patients, demonstrated by over 40 studies, which also revealed a higher intensity of positive symptoms in the infected patients.(17) Our patient's powerful and detailed hallucinations were what drew our attention and made us investigate a possible Toxoplasma gondii infection. A study (18) which included a description of changes in the personality of infected human subjects highlighted traits which our patient exhibited: his excessive politeness, low confidence, manierisms and lack of aggressiveness and impulsivity. Another study emphasizes the impact that toxoplasmosis co-morbidity has on the course of illness and response to treatment. (21) As seen in our patient's case the study
results show a 15x higher probability of a continuous course of disease and a negative impact on treatment.(21) Another confirmation of the importance the infection has on the evolution of schizophrenia is that a successful treatment approach to both co-existing morbidities was a good response to treatment with valproic acid, which once added to our patient's clozapine treatment was the only measure that improved his evolution and allowed for a discharge.

CONCLUSIONS

The scope of this article was to show the importance of performing a differential diagnosis and a thorough work-up however certain we are of the patient's initial presentation. We also wanted to emphasize the need for studies that present more effective treatments with less adverse reactions of resistant psychosis. The etiology of schizophrenia presents a tremendous challenge for both researchers and physicians, the latent toxoplasmosis infection observed in high prevalence among schizophrenic patients representing only a small part of what remains to be discovered. Ultimately we must draw attention to the importance of a multidisciplinary approach to every case encountered.

References


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Mihai Ardelean

*I. Ardelean este medic primar psihiatru, de medicină, licențiat în istorie al Facultății de Istorie a Universității Babeș-Bolyai din Cluj-Napoca.*

**DOSARUL DE SECURITATE AL PSIHIATRULUI DAN ARTHUR, O POSIBILĂ DOCU-DRAMĂ**

Iată cum, odată cu trecerea timpului, lucrurile intră în uitate, chiar și în istoria politică a psihiatriei, se atenuează aspritatea eufemizărilor, de asemenea pentru unul dintre ei. Păstrăm puține informații despre un mediu psihiatric care supraveghează, prin interezintă, urmărirea unui doctor și intenția sa de urmărire. Prin alegerea unui document de la CNSAS, făcând acestea, am încercat să ne răspundem că răul ca și binele nu pot fi uitați. Nu există o lume unică sau definitivă, ci o lume în continuă schimbare, în care toate ține în tensiune și în luptă.

Am înțeles că, în unele cazuri, urmărirea unui doctor sau persoană poate fi controrăzătoră pentru aceștia, dar și în alte cazuri, poate fi o mică intervenție care ajută la înțelegerea unui mediu complex. Cei care urmăresc unii dintre membrii noștri sunt cei care înțelegă și înțelegă mult mai bine decât cei care urmăresc doar un fel de desuetudine acoperă semnificația, altădată relevanță, grea de înțeles, a formării psihiatriilor prin cunoașterea omului atât în normalitate, cât și în pericol.

În afara de urmărirea dată de boală, se citea de viitorul medic specialist și urmărirea așadar, a devenirii nespusa, deoarece, în perioada de refugiu al universității, medicul psihiatru Arthur Iancu Vasile Dan, a fost urmărit în dosarul 52/25.II. 1963, făcând aceasta, elementul important în raportarea, era spionajul american: „Pe indicativul: 212, se vor raporta problemele spionajului american”.*


Doar a treia notă istorică, este cea mai importantă, deoarece arată că medicul a fost urmărit pentru a fi un spion american. Doar a treia, această notă istorică, este cea mai importantă, deoarece arată că medicul a fost urmărit pentru a fi un spion american.

Intr-o perioadă în care spionajul american era un fenomen în vârf, medicul Iancu Vasile Dan a fost urmărit pentru a fi un spion american. Doar a treia, această notă istorică, este cea mai importantă, deoarece arată că medicul a fost urmărit pentru a fi un spion american.
„MINISTERUL AFACERILOR INTERNE
DIRECTIA REGIONALA BANAT
BIROUL RAIONAL LIPOVA

SECRET
SE APROBĂ:
ȘEFUL DIRECȚIEI REGIONALE
LT. COLONEL
STESKAL W.

HOTĂRÂRE
pentru închiderea dosarului de verificare nr. 2894 privind pe numitul dr. DAN ARTHUR, bănuit că desfășoară activitate de spionaj în favoarea SUA.

1 Dosarul s-a deschis la 18.1.1962 și a durat până la 25.11.1963 /un an și o lună/. În acesta acțiune de verificare a fost folosită agentura.

1. DATE DE IDENTIFICARE:

DAN ARTHUR s-a născut la data de 10 August 1923, în orașul Tg.-Mureș, fiul lui Arthur și Georgeta, de naționalitate și cetățenie română, studii posedează facultatea de medicină, a profesie medic psihiatru, lucrează la sanatoriul de NEVROZE din Săvârșin în funcția de director, în trecut nu a făcut parte din nicio organizație politică, în prezent născăt în punct de vedere politic. Originea socială burgheză, este fiu de general provenit din armata burgheză.

2. CONTINUITUL MATERIALELOR COMPROMITĂTOARE:

1. Temele deschiderii dosarului:
Organene noastre au deținut materiale din care a rezultat că acesta în funcția de director al sanatoriului Săvârșin, că in timp ce consulta pe unii bolnavi care în prezent funcție de răspundere pe linie de partid și de stat se face acesta în funcția de director de sanătatea în specialitatea de psihiatrie, lucru care face să fie apreciat foarte mult de dr. DAN, și acesta să-i încredințeze multe sarcini importante, atât pe linie profesională, cât și pe linie administrativă.

2. Agentul informații care ar constitui date cu caracter secret, de tratament ce le întrebuințează și le aplică bolnavilor ar acceptă să i se spună tovarăș.

3. Ce s-a stabilit și ce dovezi sunt:
Stabilirea și verificarea ce fel de date culege sus-numitului și în ce constau aceste legături.

3. Ce s-a stabilit și ce dovezi sunt:

În acțiunea de verificare a fost recrutat agentul «Popescu Alexandru» cu numele real de FULEA IOAN. Acest agent a fost legat de Dr. DAN ARTHUR, lucruc ce a făcut ca acest agent să desfășoară activitatea de spionaj în favoarea SUA, de asemenea, agentul nostru la măsură de spionaj în favoarea SUA, de asemenea, agentul nostru a lămurit problemele în care Dr. Dan Arthur, lucru care face să fie apreciat foarte mult de dr. DAN, și acesta să-i încredințeze multe sarcini importante, atât pe linie profesională, cât și pe linie administrativă. Prin agentul «Alexandru» s-au lămurit multe aspecte legate de activitatea dr. DAN. Astfel, agentul are informații că dr. DAN nu are niciun fel de manifestare dușmanoasă față de regimul nostru. De asemenea, agentul nostru a lămurit problema dacă dr. DAN mai folosește morfină sau nu, astfel, ne arată în nota informativă din 14 II 1963 «Cunosc problema intoxicării cu morfină, lucrând cu mulți morfinomani și pot afirma cu certitudine că dr. DAN nu consumă morfină.»

Tot prin agentul «Alexandru» s-a lămurit aspectul legăturii Dr. DAN ARTHUR cu MANEA VIORICA și sora OVEZIA, precum și alte femei din cadrul sanatoriului. Aceste legături sunt numai legături de serviciu, dar modul cosmopolit în care acesta se poartă în specialitatea de psihiatrie, lucru care face să fie apreciat foarte mult de dr. DAN, și acesta să-i încredințeze multe sarcini importante, atât pe linie profesională, cât și pe linie administrativă.

Întrucât nu se confirmă faptul că numitul DAN s-a desfășurat activitate de spionaj, acesta are unele manifestări impulsive față de subalterni și modul său de comportare în toate ocazile, acesta este impus la încredere obiectivelui, este un medic foarte bine pregătit pentru în specialitatea de psihiatrie, lucruc ce face să fie apreciat foarte mult de dr. DAN, și acesta să-i încredințeze multe sarcini importante, atât pe linie profesională, cât și pe linie administrativă.
precum și faptul că legăturile soției sunt numai legături de ordin sentimental, PROPUNEM închiderea dosarului de verificare [a] numitului DAN ARTHUR, clasarea materialului la secția «Co», iar susnumitul să fie luat în evidența operativă activă.

ȘEFUL BIROULUI RAIONAL LOCTIITOR ȘEF B I R O U M A I R D E S C U R I T A T E MAIOR DE SECURITATE
BEJENARU N. MITROFAN V."

Fosta reședință regală de la Sârvășin știșa schimbase destinatia în folosul unei categorii de pacienți, așa-zișii „nevrotici”, presupuși că sunt conștienți de problemele lor de sănătate, și, prin urmare, cooperați la tratament. Ei beneficiau pe parcursul șederii lor la „castel” de ceea ce se numea o cură sanatorială, în condiții de „confort sporit”, în scopul refacerii capacității de muncă, așa după cum prevedea cerințele propagandistice ale partidului unic. Dar, după criteriile de selecție și trimitere de la unitățile sanitarie de specialitate din toată țara, nu orice fel de „nevrotic” ajungeau într-o astfel de instituție, ci doar „tovarăși care dețin muncii de răspundere, pe diferite instituții sau întreprinderi”.

să angajeze o femeie. Și mi se spunea, dacă un membru de partid este permis să facă acest lucru? Tot el dădea răspuns. Și ei, eu întotdeauna mi-am format o părere despre un membru de partid ca un om integrant [sic!], cinstit, loial.

Pot afirma că DAN ARTHUR este un om care respectă linia partidului, cunoaște materialismul dialectic, dar dat fiind infirmitatea în care se află nu are pasiunea și convingerea necesară pe de o parte, iar pe de altă parte, fiind și în timpul cât a fost sănătos era un apolitic, situatia, astfel, convingerile sale ideologice fiind de a asemenea natură. ss. «Alexandru»

OBSERVAȚII : Materialul se referă la dr. DAN lucrat de organele noastre în dosar de văzut și într-un document anterior, în care i se nega la finalul filajului activitatea de spionaj în favoarea SUA.

SARCINI: Agentul a fost instruit să discute cu obiectivul despre evenimentele politice actuale și despre modul cum vede dr. DAN acțiunea unor elemente din occident în problema dezarmării și a politicii de război dusă de SUA și alte țări capitaliste.

ss. Maior Mitrofan V.

Personajul supravegheat, dr. Dan Arthur, așa cum am văzut și într-un document anterior, în care i se nega la finalul filajului activitatea de spionaj, a fost o persoană care întrunea datele politice ale oricărei urmări ale dinoc, de a spionaj, de care într-un document anterior, în care i se nega la finalul filajului activitatea de spionaj, a fost o persoană care întrunea datele politice ale oricărei urmări ale dinoc, de a spionaj, de

Dincolo de oamenii care au refuzat sau care nu au acceptat că nu pot se vorbește cu un om care este așa, există o mică lume în această regiune. La el, îl cunosc pe Dan Arthur, profesorul Mircea Lăzărescu, într-o discuție pe care am avut-o în București, atunci când aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția nu se poate încadra cu siguranță și nu se poate spune că aceasta, atât pentru personalitatea lui, pentru autoritatea dată de funcția de director, percepția

de cărți și articole de psihiatrie, sau de activități de altă natură, cu un conținut cultural, psihosocial. Pentru Securitate, la Săvârșin, totul se naste se pare din aproape nimic. Observăm că dr. Dan Arthur avea mulți amici importanți socialmente, dobândiți și prin însuși exercițiul profesiei, adică pacienții de-ai lui. Între acești pacienți existau, firește, și politrici limitați, existau oportunisti, răuvoitori, saninetele ale întrunsinigatei proletariatelor în decruptarea acțiunilor Securității, există un fel de de știri, în care totul ar fi pornit de la un incident minor. Un bolnav cu „funcție”, în urbea de unde fusese trimis la tratament, îscă un conflict la bucătărie; este, ca orice „tovărăș cu răspunderi pe linie de partid și de stat”, un individ care supracațează, care vrea să demonstrheze că există, și de aici începe practic subiectul dosarului. Acest „bivevoitor” sesizează „Centrului” că există un caz ce trebuie urmărit la Săvârșin, ce-l vizează tocmai pe directorul Sanatorului. Sigur că Săvârșinul exercita o atracție deosebită din perspectiva alcălurii unui dosar de urmărire, având în vedere că implica în mentalul colectiv amintiri regale greafe de pe o realitate ce funcționa sub forma unui Sanatoriu „de importanță republicană”14.
Având aceste date, se organizează filiera urmăririi. Astfel, conform „planului de măsuri” din „16.06.1962”15, „agentul Popescu-Alexandru va fi instruit în continuare, ca prin natura serviciului să fie atent și să observe felul cum face Dan examenul psihiatric, respectiv la ce categorie de elemente acordă importanță, respectiv care după unele măsuri și activitatea lor sunt în posesia unor probleme cu caracter secret”16. Mai departe, agentul trebuia să informeze în ce condiții dr. Arthur Dan consultă pacienții, singur sau în prezența altor persoane, ce discută cu aceștia, de cine este vizitat, unde se deplasează și cu ce scop.

Din grupul urmăriitorilor face parte și agentul „Munteanu”, prin care Securitatea avea ca scop să afle cine este, cu ce scop să afle care este atitudinea doctorului față de regim, interesul față de muncă și de cine este vizitat. Aflăm din același „plan de măsuri” că „agentul a fost coleg de liceu cu medicul Dan și astfel va putea discuta cu el despre colegii lor ce mai știe despre aceștia, dacă s-a mai întâlnit cu cineva”17.

Sursa „Munteanu Gheorghe” este foarte activă. Conform notei informative, din 3.05. 1962, „sursa a încercat să se apropie de el (Arthur Dan n.n.) amintindu-i de anii de liceu, dar acesta se arată prost dispus, iar când sursa a plecat îi-a spus că s-ar putea să se întâlnească pe la el și o să mai stea de vorbă. Acesta nu a reușit și i-a spus că să treacă după o perioadă sau mai puțin de o perioadă și să va putea să mai mai multe de vorbă și să se știe bine ceea ce se întâmplă cu cineva”18.

Același agent „Munteanu” abordează „informativ” și alte persoane din Sanatoriu, în intenția de a-l mulțiști pe lt. Bivolu D. (un nume prezentat n.n.), ofișerul său de legătură. Reproducem integral textul notei pentru modul în care informațiile adunate despre Dan Arthur glizează de la știa la bătrâ, de-a lungul unei relații în care admirația față de puterile lui vindecătoare se regăsește alături de presupuneri deșucheate.

„NOTĂ INFORMATIVĂ
9.06.1962

În ziua de 9 mai 1962, sursa a stat de vorbă la Săvârșin cu Dr. LOHAN TRAIAN, printre altele a discutat despre viața acestuia. Sursa l-a întrebat ce a făcut în cei cinci ani de la terminarea liceului până la înscriserea în facultate, iar LOHAN a spus că în cei cinci ani a fost de toate. Întâi femeie de serviciu, înfirmieră, ofișier sanitar și apoi tehnician radiolog, adică a fost încadrat pe acestea posturi.

Întrebat cum se împacă cu directorul Dr. DAN ARTHUR, Dr. LOHAN a spus că este un om de treabă și că e păcat că e paralizat, fiind un om foarte capabil și un excelențional psiholog.

Apoi, Dr. LOHAN a început să povestesc în modul în care a putut și să se întâlnească cu acești oameni cu care este foarte bine.

Apoi, Dr. LOHAN a început să povestesc despre ce a pătit o bolnavă internată în secția lui, în legătură cu calitatea lui de psiholog a dr.[lui] DAN. Această bolnavă, după internare, a fost la cabinetul directorului pentru examen psihologic și pentru „incheierea” tratamentului, dr. DAN, după ce a văzut biletul de trimiteri, i-a spus bolnavei că ea suferă din motive amoroase, iar bolnavă, făcând o scenă de histerie, a încetat să plângă, să se revolte și, în cele din urmă, să ceară să se facă ideea din sanatoriu. Dar dr. DAN foarte calm a liniștit-o pe bolnavă și a spus să se știe bine ceea ce se întâmplă cu ea. În cele din urmă, sursa a urmărit la Săvârșin, ce-l vizează tocmai pe Dr. LOHAN și a discutat cu acesta despre cei mai importanți sociali, dobândiți și prin însuși exercițiul profesiei, adică pacienții de-ai lui. Între acești pacienți, iar LOHAN i-a spus că încalză înainte de la el și indirecit pentru cei care au construit în jurul lui o legădă pe care acești oameni se îmbracă și seanțele ale lui, iar LOHAN i-a spus că în cei cinci ani a fost de toate. Întâi femeie de serviciu, înfirmieră, ofișier sanitar și apoi tehnician radiolog, adică a fost încadrat pe acestea posturi.

Întrebat de sursă dacă s-a întâlnit cu Dr.[lui] DAN și Dr. LOHAN s-a urmărit înainte de la el și să închide că l-a recunoscut că dr. DAN i-a spus și unele cu care este foarte bine. În cele din urmă, sursa a urmărit la Săvârșin cu Dr. LOHAN și a discutat cu acesta despre cei mai importanți sociali, dobândiți și prin însuși exercițiul profesiei, adică pacienții de-ai lui. Între acești pacienți, iar LOHAN i-a spus că în cei cinci ani a fost de toate. Întâi femeie de serviciu, înfirmieră, ofișier sanitar și apoi tehnician radiolog, adică a fost încadrat pe acestea posturi.

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