S25A

A longitudinal study of global coherence in life narratives from age 8 to 70

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Keywords: Life story; Autobiographical memory; Global coherence; Identity

When telling the own life story the individual is challenged to construct a coherent narrative, which is a cognitive and narrative performance. Not only the listener, but also the narrator wants to bring the multiple single events of his life into a coherent organization in order to demonstrate the own biographical development and to justify how one has become the person the one is at present. In a longitudinal study a total of 531 life narratives were collected in three waves. Since 2003 the participants of six age groups (presently 16, 20, 24, 28, 44 and 70 years old, 145 participants) told us their life stories every four years. We studied the development of global coherence of life narratives over almost the entire lifespan (8-70 years) by coding linguistic indicators at the level of propositions, by rating the global impression of listeners, by analyzing in terms of how well-formed the beginnings and endings of the life stories are and whether they follow a linear temporal order. The findings of the third wave replicate prior cross-sectional findings on development of global coherence in life narratives across adolescence and confirm them longitudinally. Temporal coherence is developed by midadolescence. By the age of 12, the majority of life narratives began with birth, ended in the present and followed mainly a linear temporal order. Regarding the overarching linear temporal macrostructure, it turned out that from age 20 on, the use of well-formed beginnings and endings and the maintenance of a comprehensible linear temporal order were well established. Causal-motivational coherence is developed by young adulthood and thematic coherence only in mid-adulthood.

Further readings

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S25B

Role of emotion regulation processes in the organization of autobiographical memories in patients with anorexia

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Keywords: Anorexia; Emotion regulation; Autobiographical memory; Narratives

A deficit of emotional regulation is now classically described in the development and maintenance of eating disorders [4]. These difficulties in regulating emotional states are characterized by more limited access to emotion regulation strategies but also a predominant use of unsuitable ones such as avoidance, suppression and lack of flexibility (perseveration of emotional states) [1]. We assume that the use of these emotional strategies could lead to specific recall of autobiographical memories and so a specific construction of their life story and their identity. We showed in a first study [3], that the autobiographical memory of anorexic patients is characterized by an overgeneralization mechanism for both positive and negative memories. The use of such a cognitive avoidance strategy modifies the access to autobiographical emotional memories by retrieving positive or negative memories less specifically. Moreover, this impairment is reinforced by illness duration. In a second study [2], we studied the dynamics of emotions in anorexic patients' autobiographical speech. The temporal pattern of emotional expression was studied in transforming the autobiographical narratives into symbolic sequences of positive, negative, and neutral emotional expressions. The computed dynamic indices showed in patients' speech a cycle of negative emotions and silence. These results showed specific dynamics of emotional expression in persons with anorexia characterized by the presence of negative emotional perseveration. These changes in the processes of autobiographical memories organization support the hypothesis of changes in the construction of their identity. We present two methods for a psychotherapeutic work on the construction of autobiographical memory. A first one consists in programs stimulating the specific autobiographical memories by using olfactory or visual media, the other is focused on remediation methods seeking to modify the cognitive and emotional flexibility of these patients [5].

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S25C

Le récit de vie des patients souffrant de schizophrénie

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Mots clés : Récit de vie ; Cognition ; Émotion ; Anorexie ; Schizophrénie

Des troubles de l'identité personnelle sont décrits depuis longtemps dans la schizophrénie, or les mécanismes cognitifs de ces perturbations restent encore mal compris. Afin de mieux comprendre ces mécanismes, nous avons exploré la façon dont les patients souffrant de schizophrénie organisent le récit autobiographique de leur vie. Nous avons ainsi analysé la cohérence causale des récits de vie de patients en les comparant aux récits de sujets contrôles. Nos résultats montrent que les récits des patients contiennent moins de liens entre les événements qu'ils ont vécus et leur identité que les récits des sujets contrôles. De plus, ces liens correspondent davantage à des relations de causalité élémentaires et moins à des réflexions plus complexes reliant les événements vécus à l'identité, et les intégrant dans le contexte plus général de l'ensemble de la vie de l'individu. Ces éléments indiquent que la cohérence causale des récits des patients est diminuée. Nous avons enfin trouvé que la diminution de la cohérence des récits est corrélée positivement

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aux troubles exécutifs des patients. Ces résultats suggèrent que les troubles cognitifs présents dans la schizophrénie pourraient altérer la capacité des patients à établir des liens entre les événements marquants de leur vie et leur identité. Ces altérations pourraient rendre compte d'une construction défaillante de l'identité chez les patients et constituer une cible d'intervention thérapeutique spécifique.

Pour en savoir plus

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Dépression du sujet âgé

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S30A

Prévalence et comorbidités de l'épisode dépressif majeur du sujet âgé en population générale

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Mots clés : Épisode dépressif majeur ; Sujet âgé ; Épidémiologie

L'évolution démographique confronte nos pratiques aux spécificités liées au vieillissement de nos patients. Ainsi, par son impact en termes de morbi-mortalité, la dépression du sujet âgé constitue un enjeu majeur de santé publique. Ce trouble est connu pour avoir un fort impact en termes de morbi-mortalité [1]. La prévalence de l'épisode dépressif majeur actuel chez le sujet âgé en population générale est estimée entre 1 et 5 %. En population française, l'étude ESPRIT indique une prévalence de 3,1 % [4]. Des données récentes issues de la plus importante cohorte de sujets âgés en population générale américaine (plus de 8000 sujets de plus de 65 ans) confirment ces chiffres de prévalence [2]. La prévalence sur douze mois en population générale de l'épisode dépressif majeur a été évaluée à 2,6 % (écart type = 0,22) chez les sujets âgés d'au moins 65 ans, avec une forte association avec la dysthymie, la dépendance à l'alcool et au tabac, les troubles anxieux et de personnalité [3]. Plusieurs biais méthodologiques, dont le recours à des instruments d'évaluation peu adaptés aux sujets âgés, sont susceptibles de sous-estimer cette prévalence. Contrairement à l'idée communément admise, l'handicap ressenti par le sujet de l'épisode dépressif majeur n'est pas différent chez le sujet âgé comparativement aux sujets plus jeunes. Ces deux populations diffèrent cependant dans le délai de prise en charge qui demeure plus important chez les sujets âgés [3]. Ces résultats épidémiologiques incitent le praticien et en particulier les médecins généralistes consultés en première ligne à dépister plus systématiquement ce trouble afin d'en améliorer la prise en charge.

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S30B

Access to mental health care in depressed older patients

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Keywords: Older; Depression; Pharmaco-epidemiology; Treatment

Late-life depression presents clinical challenges, including more comorbidities, longer time to treatment response, longer treatment duration, and older age stigmatization. Such characteristics may increase the perception that depressed older adults are difficult to treat, but evidence suggests that benefits from treatment are similar to these observed in younger adult patients. Antidepressant treatment may confer even greater protection against suicide in older than younger adults. However, a retrospective matched cohort study carried on in American managed care population showed that depression goes commonly untreated in older people compared with younger adults. Despite a high rate of comorbidity that was associated with more frequent antidepressant dispensing, this age group was at higher risk of untreated illness either by antidepressant (25.6% vs. 33.8%) or by psychotherapy (13.0% vs. 34.4%) and of later treatment after depression diagnosis (51 vs. 14 days), showing a lower access to treatment. In this study, before 2006, older adults treated for depression received more frequently antidepressants at lower prescribed doses, had poorer adherence and higher non-persistence to treatment than younger adults. However, these differences disappeared or reversed after Medicare Part D implementation, which improved the refunding of drugs in the elderly population. Similarly, a historical cohort study showed, in the French universal health care system, that antidepressant treatment duration and adherence were better in the treated older patients than in the younger ones. This favourable finding may be partly attributed to the universal healthcare system in which all subjects are treated in the same way, regardless of age. However, the reasons for the more appropriate use of antidepressants in the older subjects remain to be elucidated.

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S30C

Risque suicidaire chez le sujet âgé et modalités de prise en charge

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