Le corps au repos d'un sujet nous en apprend beaucoup sur la façon dont son histoire s'est inscrite dans sa chair, sur sa présence au monde, les affects profonds qu'il véhicule, son degré d'unité ou de dysharmonie (fragmentation).

Si on met le corps du sujet en mouvement, de facon non douloureuse, il émerge fréquemment des contenus spécifiques, chargés émotionnellement, souvent régressifs, qui vont indiquer le type de transfert central, les résistances, tant psychiques que corporelles. J'ai nommé cela un processus *d'activation transférentielle.* L'anamnèse sexuelle et l'exploration corporelle aident ainsi à situer et formuler la problématique centrale du sujet, ce qui va constituer pour le thérapeute une sorte de fil rouge bien nécessaire au long du processus, lors des inévitables périodes de confusion et de doutes qui accompagnent la thérapie.

De nombreux exemples illustreront cette théorie et cette pratique thérapeutique.

DEPERSONALIZATION: PSYCHOPATHOLOGY AND PHILOSOPHY

E. Bezzubova.

The present is an attempt to discuss the "double" nature of depersonalization (D) as a syndrome and as a psyche phenomenon. D in 117 patients were assessed. D may be considered as a developmental disorder of self-awareness, characterizing by features of distortion of puberty identity crisis. Three types of D correlating with disturbances of correspondent dimensions of self-awareness development are described: vital, derealization, mental. The psychopathological root of D as a syndrome probably is a quality of vitality — a vulnerability of primary dimension of self-awareness development, so called "feeling of existence". Continuum of vital, protopathic sensations could be regarded as a line, connecting D with obsessions, perception and delusional disorders. Two kinds of such disorders may be distinguished: somatofom, correlated with body image and "ideation" correlated to mental activity. Phenomenological root of D as a psyche, metaphysical phenomenon seems to be considered as a kind of "virtual reality Self", creating by selfreflection in aspiration to comprehend the essence of human being and the sense of being for constructing the actual "Self-true" reality.

PSYCHOMETRIC FEATURES OF THE FRENCH VERSION OF DEFENSE STYLE QUESTIONNAIRE (DSQ)

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Bond et al. [1] developed a self questionnaire measuring empirically conscious derivatives of defense mechanisms. According to them, the term defense mechanisms is used to describe not only an unconscious process, but also behaviour that is either consciously or unconsciously designed to reconcile internal drives to external demands. DSQ has been translated and validated in many different languages. Original analysis yielded 4 factors called Defense Styles (DS): (I) Maladaptative action pattern (II) Image distorting style (III) Self sacrificing style (IV) Adaptative defense style. Depending on environment and language, these factors do not contain exactly the same individual mechanisms of defense (MD), but remain clinically relevant. DSQ discriminates mature and immature DS. *Objectives:* Determine if the french version of DSQ has (1) a similar structure than the original version (2) Internal consistency (3) Grouping of MD in clinically pertinent DS (4) Correlation with Defensive Functioning Scale (DFS) (DSM-IV) (4) non patients use more mature DS. *Preliminary results:* Factor analysis of probants (n = 68) sample yielded 4 factors ranging from mature to immature DS (I) Acting out, Help rejecting complaining, Regression, Inhibition, Projection, Somatization, Projective indentification (II) Suppression, Omnipotence, Isolation, (-) Pseudo altruism (III) Sublimation, Reaction formation, (-) Splitting (IV) Anticipation. DSQ scores on factor I are significantly higher (mean diff. = 1.12, DF = 187, t-value = 6.16, $p < 0.0001$) in outpatients group (n = 113) than in probants (n = 76). Factor I score is negatively correlated with score on DFS, if patients at the level of "dysregulation of defense" level are excluded (n = 40, $r = -0.40$, $p = 0.01$). Patients with psychotic functioning tend to underscore MD on DSQ. Scores on other factors are not different in the two groups. *Conclusion:* Factor structure of the french version is similar to the original scale, although minor differences in individual MDs are present. DSQ cannot be used with patients functioning at a dysregulation of defense level, probably because of denial and lack of insight. DSQ remains an easy and economical way to discriminate mature and immature defense style in populations of "neurotic" patients. Defense Functioning Scale of DSM IV seems difficult to use without specific training.

[1] Bond M, Gardner ST, Christian J, Siegel JJ: An empirically validated hierarchy of defense mechanisms. Arch Gen Psychiatry 1983; 40: 333–338.

THERAPEUTIC DIALOGUE IN PSYCHIATRY AND PROBLEMS OF CONSCIOUSNESS

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In our clinical practice we deal with the inner world of patients. Therefore the spiritual life of a human being is the initial point and object of any investigation in psychopathology.

From this point of view all the problems of general psychopathology centre round a way of penetrating into man's consciousness.

The only reality comprehensible for us is consciousness of a human being that may be understood through real process of communication between doctor and patient.

Since communication is realised between subjects, intersubjectivity is intrasubjective by its nature, that is a part of the theory of subject, i.e. "ego".

However speaking about "ego" we are hardly able to understand the initial stages of any communication both normal and pathological without theoretical grounds for understanding the mechanisms of consciousness.

In our work of 1991, following Bahtin's viewpoint, we showed that normal, clear consciousness is a dialogue between architectonic structures "ego" and "second self" while chronological shifts of the dialogue create man's feelings and thoughts.

Theoretical foreground for understanding of pathological dialogue or monologue within the framework of the new concept of consciousness enables us to see the role of psychiatrist at all the stages of the therapeutic dialogue with patient.

On the one hand psychiatrist diagnoses the state of patient's consciousness and on the other hand knowing the new methods psychiatrist is able to solve the problem of reparation of patient's dialogical consciousness by means of communication with him.

PERSISTENCE, VANISHING AND DEVELOPMENT OF RESPONSIBILITY AND DANGEROUSNESS. THE ITALIAN CASE

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The etymological reconstruction of the meaning of the terms Responsibility and Dangerousness helps to show that the convergence between the sense-evolution of these words and the effects of the "180 Law" promulgated in 1978 (low which did not include in its text the word Dangerousness and which did reduce the Responsibility of psychiatrists) produced in the psychiatric field a progressively increasing

carelessness of those forms of mental infirmity which bring the deep sense of our two terms into play. But Dangerousness, hidden in the Sanitary Law folds concerning the Obligatory Sanitary Treatments, persists, unchanged and in clear letters, within the articles of the penal laws which regulate the internment of the insane author of a crime.

The Jail, the Psychiatric Judiciary Hospital, the Services for Drug Addiction Treatment, which represent privileged lookout-points, remark themselves that the evolution of psychiatric clinic at the ending of the millennium has necessarily to deal with some changes both of the structure and of the form. In the present report these changes are evaluated through the parallel changes of the psychiatrist's position when compared with the two figures of Responsibility and Dangerousness.

The clinical and therapeutic "rehabilitation" of these two terms, would contribute to reverse the degeneration of their meaning respectively into Solidarity and Wickedness. The new clinical forms of the mental illness, such as personality disorders with antisocial behaviour, impose this "rehabilitation". Indeed, the Responsibility denied in the formulation of the Sanitary Law, comes back to the psychiatrist through side-roads. One of these being the psychiatrist taking the therapeutic Responsibility in the interdisciplinary treatment of those increasing forms of mental disease in which the antisocial behaviour, and therefore the matters of Justice, hold a prominent position.

VOTING BEHAVIOUR OF CHRONIC MENTALLY ILL OUTPATIENTS IN GERMANY

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We report the results of a survey held immediately after the 1994 general election for the German parliament. Questionnaires on voting decisions and attitudes towards elections were received from 114 mentally ill residents of nine different therapeutic residential facilities, i.e. halfway houses, group homes and sheltered apartments.

In contrast to the general population of their surrounding neighbourhood (numbers shown in parentheses), patients favoured political parties of the 'left wing'. The Social Democrats received 55.1% (36.4%) of the votes and the ecologist party 16.9% (9.7%). On the other hand only 23.6% (46.8%) of the patients voted for the conservative parties with no votes for the Liberals. This pattern of voting remained stable concerning age, sex and type of housing. Attending general elections was rated important with a medium of 4.84 on a six-point-scale (6 = very important ... 1 = totally unimportant). An analysis of reasons for voting decisions revealed most patients' reasons to be similar to these of the general population (party program, candidate, voting habits), while a substantial proportion of 21.5% related their voting decision to the statement that the party of their choice (Social Democrats only) might do more for mentally ill people.

In contrast to earlier reports from comparable populations, we found that in favouring the 'left wing' parties the voting behaviour of chronic mentally ill outpatients from therapeutic institutions differs from that among the general population. For a small but substantial proportion the voting decision is based on the belief that the party of choice supports the interests of mentally ill clients. We suggest that these results demonstrate the voting decisions of mentally ill clients to be interest-related as among other pressure groups. We see this as an indication of a much more 'normal' voting behaviour than if patients were to exhibit the same voting behaviour seen among the general population.

CONTRIBUTING FACTORS AND PERSONALITY PROFILES IN LONG-TERM SATISFYING MARRIAGES

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This study aims to identify and assess the extent of impact of contributing factors in long-term satisfying marriages and relate them to personality profiles. Sample consists of ten couples married between 25 and 46 years. Additional research was performed with ten couples who have recently divorced after ten or more years of marriage. Quality of life and specific interactional, behavioural patterns were examined by: Dyadic Adjustment Scale, while personality profile data were obtained through Millon Clinical Multiaxial Inventory. Results indicate existing correlation of socio-demographic, communicational factors and motivation to live together on one hand, and certain personality traits on other. This is a pilot study of a larger multi-centric, international project targeting to distinguish contribution factors and personality traits relevant to long term satisfying marriage.

RESEARCH ACTIVITY BY SENIOR REGISTRARS IN PSYCHIATRY

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Objectives. To clarify how Senior Registrars use their allocated research time, and to identify specific difficulties that prevent successful research being carried out.

Methods. A questionnaire was sent to all Senior Registrars in Psychiatry in the Yorkshire and Northern Region.

Results. 99 questionnaires were sent, and 57 (58%) questionnaires were received (56.1% males and 43.9% female). 45% of the responses were from full-time and 12% from part-time Senior Registrars. 80.8% were first, second or third years, and all specialties were represented.

84.2% of trainees were actively involved in some form of research, but 61.4% identified specific problems in carrying out their research including interference from clinical work. Between 66.7% and 84.2% felt that they did not have the skills necessary to use a computer, word processor or carry out a CD ROM literature review. 60.7% of trainees received 6 or fewer research sessions per month despite the recommendation being 8 per month. Only 21.1% reported a lack of interest as being the main reason why their research was being hindered. 61.4% felt that they received adequate supervision and support from trainers, but only 28.1% felt that this was "good". Overall 41% said that they believed their research training was either poor or non-existent.

Conclusions. Research by Senior Registrars is often held back by practical difficulties. It is suggested that there needs to be greater understanding of how Senior Registrars use their research time and the difficulties associated with involvement in research. The College may have a key role to play in this through its network of Regional Research Co-ordinators.

A PSYCHOPHARMACOTHERAPEUTIC STANDARD IN A GENERAL HOSPITAL

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The author is developing a pharmacotherapeutic standard in a general hospital. In 1988 he concluded from an investigation of different aspects of benzodiazepine dependence that an *indicating protocol* is needed, if psychotropic drugs are to be prescribed adequately. In many instances a *specific indication* for treatment with psychotropics is lacking. Thus in order to treat psychiatric patients adequately the process