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

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