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2005

GRANGER B., ALBU S.

The haloperidol story.

Ann. Clin. Psychiatry, 17 (3), 137-140, 2005

(Services cités : Psychiatrie Adulte)

Haloperidol was synthesized on the 11th of February 1958 at the Janssen Laboratories, in Belgium. Soon after its synthesis and animal studies, which suggested to Paul Janssen and his colleagues that this butyrophenone drug would be of great interest as its action was similar but much more powerful than that of chlorpromazine, haloperidol was administered to humans at the Liege hospital. The subsequent clinical studies confirmed that this new drug was particularly active against delusions and hallucinations. The introduction of haloperidol in the United States of America was difficult for clinical and legal reasons. For many years, haloperidol had been widely used in western countries, until the introduction of "new antipsychotics."

2004

GRANGER B.

in: *La Dépression*. (Granger B. eds.)

Le Cavalier Bleu (), 2004, pp..

(Services cités : Psychiatrie Adulte)

2003

FRIEDMAN S., VILA G., EVEN C., TIMSIT J., BOITARD C., DARDENNES R., GUELFU J.D., MOUREN-SIMEONI M.C.

Alexithymia in insulin-dependent diabetes mellitus is related to depression and not to somatic variables or compliance.

J. Psychosom. Res., 55 (3), 285-287, 2003

(Services cités : U580, Psychiatrie Adulte, Immunologie Clinique Adulte, Pédo-Psychiatrie)

OBJECTIVES: To assess the prevalence of alexithymia in insulin-dependent diabetic mellitus (IDDM) outpatients. To examine whether alexithymia is associated with diabetic somatic variables, depression, and compliance. **METHOD:** Our sample comprised 69 diabetic outpatients followed in a university hospital. We assessed the prevalence of alexithymia (26-item Toronto Alexithymia Scale, TAS-26) and the relationships among alexithymia, depression (13-item Beck Depression Inventory, BDI-13), somatic diabetic variables (glycosylated hemoglobin, number of mild or severe hypoglycemia, somatic complications), and compliance (observer-rater scale completed by diabetologist). **RESULTS:** The prevalence of alexithymia in IDDM patients was low (14.4%). Alexithymia and depression, as measured by TAS-26 and BDI-13 scores, respectively, correlated with each other. Alexithymia was not correlated with glycemic control, somatic complications, or compliance. **CONCLUSION:** In our sample, alexithymia was related to depression and not to somatic factors or compliance.

GRANGER B.

La dépression est-elle une mode ?

Recherche, (363), 34-40, 2003

(Services cités : Psychiatrie Adulte)

MENINGAUD J.P., BENADIBA L., SERVANT J.M., HERVE C., BERTRAND J.C., PELICIER Y.

Depression, anxiety and quality of life: outcome 9 months after facial cosmetic surgery.

J. Cranio. Maxillofac. Surg., 31 (1), 46-50, 2003

(Services cités : Psychiatrie Adulte, LEM)

OBJECTIVE: The request for cosmetic surgery is of a psychological nature. Very few studies have quantitatively assessed whether or not this psychological need was actually satisfied, and more precisely, which psychic components were satisfied. **Material & Methods:** This is a multicentric, prospective cohort study. One hundred and three patients scheduled for facial cosmetic surgery from three different hospitals were examined before and after surgery using four assessment scales validated using European populations. The Montgomery and Asberg depression rating scale (MADRS) measured the existence and intensity of depression, the self-assessment test of thoughts in social interaction (SISST) measured the positive or inhibitory thoughts in the context of social relationships, and the European quality of life 5 dimensions (EQ-5D) (generic test) measured the quality of life. In addition, a semi-directive interview was specially created by our team. For statistical analysis, ANOVA and Student's t test were applied. **RESULTS:** Twenty-four patients were lost to follow-up. Although the initial MADRS index was high ($p < 0.05$), it did not change after surgery ($p > 0.1$). SISST+ (positive thoughts): the social anxiety of the individual examined was significantly greater than that of the control group ($p < 0.005$) and improved after surgery ($p < 0.01$). The SISST- (inhibitory thoughts) did not change ($p > 0.1$). The EQ-5D visual analogue scale (VAS) did not reveal any difference ($p > 0.1$) while the descriptive EQ-5D demonstrated over-representation of anxiety/depression ($p < 0.01$), and an improvement of this ($p < 0.05$) postoperatively. The mean subjective satisfaction index was 8.1 (scale of 1-10) without sharing any influence of the complications suffered (65% of the patients made self-assessments). **CONCLUSION:** The best indications for facial cosmetic surgery seem to be a lack of self-confidence associated with a desire for social interaction, and a request focused on a specific physical feature. The results presented add documentary confirmation to the impression shared by the majority of cosmetic surgeons. However, it was also confirmed that cosmetic surgery is not limited to its technical components, but remains a medical act which must consider the overall effect on the whole patient.

PLAGNOL A., OITA M., MONTREUIL M., GRANGER B., LUBART T.

The fragmentation of representational space in schizophrenia.

Encéphale. Rev. Psychiatr. Clin. Biol. Thérap., 29 (5), 401-411, 2003

(Services cités : Psychiatrie Adulte)

Existent neurocognitive models of schizophrenia converge towards a core of impairments involving working memory, context processing, action planning, controlled and intentional processing. However, the emergence of this core remains itself difficult to explain and more specific hypotheses do not explain the heterogeneity of schizophrenia. To overcome these limits, we propose a new paradigm based on re-presentational theory from cognitive science. Some recent developments of this theory enable us to describe a subjective universe as a representational space which is displayed from memory. We outline a conceptual framework to construct such a representational space from analogical -representations that can be activated in

working memory and are connected to a network of symbolic structures. These connections are notably made through an analytic process of the analogical fragments, which involves the attentional focus. This framework allows us to define rigorously some defense processes in response to traumatic tensions that are expressed on the representational space. The fragmentation of representational space is a consequence of a defensive denial based on an impairment of the analytic process. The fragmentation forms some parasitic areas in memory which are excluded from the main part of the representational space and disturb information processing. The key clinical concepts of paranoid syndromes can be defined in this conceptual framework: mental automatism, delusional intuition, acute deconstruction, psychotic dissociation, and autistic withdrawal. We show that these syndromes imply each other, which in return increases the fragmentation of the representational space. Some new concepts emerge naturally in this framework, such as the concept of suture which is defined as a link between a parasitic area and the main representational space. Schizophrenia appears as a borderline case of fragmentation of the representational space. This conceptual framework is compatible with numerous etiological factors. Multiple clinical forms can be differentiated in accordance with the persistence of parasitic areas, the degree of fragmentation, and the formation of sutures. We use this approach to account for an empirical study concerning the analysis of analogical representations in schizophrenia. We used the Parallel Visual Information Processing Test (PVIPT) which assesses the analysis of interfering visual information. Subjects were asked to connect several small geometric figures printed on a transparency. The transparency was displayed above four photographs which were the interfering material. Then, subjects completed three tasks concerning the photographs: a recognition task, a recall task, and an affective qualification task. Using a case-by-case study, this test allows us to access the defense processes of the subjects, which is not possible with the usual methods in cognitive psychopathology. Twelve clinically-stable schizophrenic subjects participated in the study which also included a self-assessment of alexithymia by the Toronto Alexithymia Scale. We obtained 2 main results: (a) creation of items in recall or false recognition by 8 subjects, and (b) lack of the usual - negative correlations between the alexithymia score and the recall, recognition and affective qualification scores in the PVIPT. These 2 results contrast with what has been previously observed for alexithymia using the same methodology. The result (a) confirms an interfering activation in schizophrenic memory, which can be interpreted in our framework as indicative of parasitic areas. The creation of items suggests the formation of sutures between the semantic content of photographs and some delusional fragments. The result (b) suggests that the apparent alexithymia in schizophrenia is a defense against interfering activation in parasitic areas. We underline the interest of individual protocols to exhibit the dynamic interplay between an interfering activity in memory and a defensive flattening of affects.

SANTIAGO-DELEFOSSE M., CAHEN F., COEFFIN-DRIOL C.

The analysis of physicians' work: announcing the end of attempts at in vitro fertilization.

Encéphale. Rev. Psychiatr. Clin. Biol. Thérap., 29 (4), 293-305, 2003

(Services cités : Psychiatrie Adulte)

The purpose of this empirical study is to analyze modalities of announcing the end of attempts at in vitro fertilization to women who, for various reasons, were not able to have a child after several trials. What are the problems physicians face when, in the course of their work, they make these announcements ? How do they give (or not give) support to these women who have placed so much hope in this technique ? These are some of the questions that led the authors to conduct this empirical study within the framework of a clinical and qualitative approach to work

psychology. Within this framework, work is conceptualised as a complex activity that involves the subject, both bodily and through his various modes of socialisation. The field of clinical and qualitative approach to work psychology situations focuses on different ways of expressing distress related to contradictory work demands, as the activity is being performed; it also focuses on those creative processes used by the subject to cope with those internal and external conflicts that hinder task performance. A review of the literature and preliminary observations led us to postulate that the problems physicians are faced with when they announce the end of attempts at in vitro fertilisation (IVF) are linked to several conflicts between work values (that are specific to the medical world) and the recognition of work failure: termination of attempts at IVF. The population that participated in this research project belongs to a network of private practitioners who work with the in-house team of a Parisian clinic. But the group is not uniform and some physicians perform IVFs more frequently than others. Our qualitative study involved 10 semi-directive interviews of approximately 1 1/2 hours each, which were recorded and transcribed. Initial instructions focused on "a concrete description of situations of abandonment of attempts at IVF, in terms of their preparation, development, and the way they are experienced". Interviews therefore centred on specific and limited practitioner activity. Each transcription was submitted to a Qualitative Analysis of Discourse, followed by a comparative analysis of the 10 transcriptions. We propose an original method of Qualitative Analysis of Discourse, to be applied to semi-structured clinical interviews. This method seeks to analyse the structure of the "resulting egocentric monologue" (36) in research situations of semi-directive interviewing. The method of Qualitative Analysis of Discourse involves three steps, but only the first two were applied in this work: a) identification of sequences of discourse; b) analysis of relationships between statements; c) stylistic analysis of figures of speech. Our first set of analyses showed that several markers increase in physicians' discourse when they describe difficult and/or conflict-laden consultation situations: logical connectors, impersonal pronouns, reported discourse, anticipations regarding the interviewer's judgement. The logical balance of the discourse therefore appears threatened when problems inherent in the work demands involved in ending IVF attempts are mentioned. As a whole, these markers underscore the importance of the implicit dimension of discourse (inferences, presuppositions, hints, allusions, etc.), thus reflecting complex speech that attempts to negotiate between subjective positions and shared cultural values. A comparative analysis of the markers identified in the 10 interviews revealed four areas, each involving nervous tension poles, that are suggestive of cognitive-emotional dissonance in the task to be performed. Some factors act upon the work situation itself on the one hand, and on the working relationship between physician and patient on the other. 1. Areas of tension relating to the task to be performed. The first area contrasts individual with collective decision-making. The independent status which characterises private medical practice increases self-esteem in cases of success but weakens it when IVF attempts fail. In addition, it goes against collective involvement in the work situation, yet such involvement may act as a strong moderating factor for the experience of distress. The second area contrasts work "that is well done" with recognition by peers. Indeed, in the hierarchy of medical values, recognition by peers that work has been well performed is anchored in "successful healing" (in the broad sense of the term), whereas in situations of abandonment of IVF attempts, ending the attempt is considered by everyone to be a failure, even if it has been "well conducted". The third area opposes "objective", medical practice to a necessarily "subjective" medical involvement. The scientific and ideal values which characterise medicine reflect its objective and scientific orientation, but IVF situations are a reminder that medicine is not an exact science and that it can make mistakes. There are numerous "special individual" cases which reduce certainty that a decision to terminate IVF is well-founded. The

fourth area distinguishes between work that is considered to be "well done" and work considered to be "well conducted". Personal estimation of work that is "well done" is based on the impression that "the maximum feasible has been done". But in IVF situations, constant uncertainty leads to professional over-involvement (examinations, verifications, changes of protocols). Work that is "poorly done" is work that does not cure or that brings no relief. As a result, work that consists in ending IVF attempts, even if it is "well conducted", remains a subjective failure for everyone since it does not bring a cure (pregnancy).

2. Areas of tension in the physician-patient relationship. The first area contrasts women's "irrational desire" with possible support from their husbands, when the time has come to announce the end of the attempts. But this voice/presence of husbands is considered desirable and important only when attempts have failed, so that husbands are not encouraged to participate in the protocols except to help restrain their wives' "over reactions". The second area opposes respect for the patient role with demands made by women. Lack of respect for the patient role, by making demands or by refusing to follow advice, particularly when IVF attempts are abandoned, crystallises all the resentment experienced by physicians in difficult work situations. Two cognitive-emotional worlds, more or less tuned to one another over the course of the IVF, start to clash and lose all mutual understanding: the medical world and the patient's subjective world. The third area results from the second one. It contrasts a "listening" physician with a "powerful" one. Physicians are very concerned that their relationship with their patients be one of partnership. But this (idealised) equilibrium is abruptly disrupted by the end of the attempts, inasmuch as it is the physician who has the power to stop these attempts and who decides to do so. The unveiling of this reality of a power relationship becomes a source of suffering and contradicts expressed surface values. The fourth area contrasts an attitude of ongoing patient support based on a belief in success with an attitude of "patient support" based on the prediction. Indeed, for a patient to be "supported" in a way physicians would consider "right and adequate", the abandonment of IVF attempts should be anticipated in advance so that the physician can prepare both himself and the patients for the high risk of failure. But physicians insist on the fact that medical work can only succeed if they "believe in it". As a result, the more energy the physician puts into launching the initial phase of IVF, the greater the feeling of self-accomplishment during the first phase of IVF; but conversely, the weaker the efficacy of the process of "seeing the patient through" the end of the attempts, the stronger the feeling of subjective distress at work will be. Overall, it is a paradoxical work situation for physicians to have to anticipate the interruption of IVF attempts and to have to prepare for, "seeing the patient through" this abandonment. This situation creates conflicts of representations and values within their very practice and generates distress at work. It is worth noting that some moderating factors could alleviate their sense of suffering and contribute to improving their work experience: a) the development of a protocol for "seeing patients through" the end of IVF attempts, which would make abandonment part of a job "well done" for physicians; b) regular participation by the spouse in these protocols; c) making all decisions to end IVF attempts a collective process, in order to avoid placing exclusive responsibility on the treating physician. The limitations of this study are inherent both in the qualitative nature of the data that involve a small number of physicians, and in the specificity of this population that works within a poorly structured network. On the other hand, our method of Qualitative Analysis of Discourse can be applied to all types of discourse obtained in research situations, provided the discourse is produced through semi-directive or non-directive interviews,

2002

CREMNITER D.

Fulminant coma: think hyperammonemia and urea cycle disorders.

Évol. Psychiatr., 67 (4), 690-700, 2002

(Services cités : Psychiatrie Adulte)

We examine the results linked to the work and experiences of practice in the emergency medical psychological units created by public authorities in 1997. Many clinical examples allow to discover another time traumatic neurosis or war neurosis which are actually observed in the frame of disaster events. These latter respond to a classical definition including the psychosocial criteria. Modalities of treatment and notably early psychotherapeutic intervention are described by specifying characteristics of "french" debriefing. This allows to clarify the distinction between french and anglo-saxon model. Other aspects of this new type of psychiatry are considered : the interaction with medias and the characteristics of this new practice of institutional psychiatry with a type of exercising psychiatry which remains fragile and which is characterized by certain original aspects in the-actual landscape of psychiatry.

DEBRAY Q.

in: *L'Impatiente de Freud*. (Debray Q. eds.)

Albin Michel (Paris), 2002, pp.1-290.

(Services cités : Psychiatrie Adulte)

2001

MENINGAUD J.P., BENADIBA L., SERVANT J.M., HERVE C., BERTRAND J.C., PELICIER Y.

Depression, anxiety and quality of life among scheduled cosmetic surgery patients: multicentre prospective study.

J. Cranio. Maxillofac. Surg., 29 (3), 177-180, 2001

(Services cités : LEM, Psychiatrie Adulte)

Objective: To measure cosmetic surgery patients' state of psychological vulnerability. Method: A multicentre prospective study was carried out in three hospital departments. One hundred and three patients scheduled for cosmetic surgery were examined using a structured interview and using three assessment scales: the MADRS (Montgomery and Asberg Depression Rating Scale), the SISST (Social Interaction Self Statement Test) and the EQ-5D (EuroQol) which measures quality of life. Results: The MADRS index was higher than that of the control group ($p < 0.01$) with 20% depressive patients, SISST: the social anxiety was greater than that of the control group ($p < 0.001$), The EQ-5D visual analogue scale average was 77.39% indicating that there was no significant difference when compared with the control group, but the descriptive EQ-5D revealed an overrepresentation of the anxiety/depression category ($p < 0.01$); 50% had already taken psychotropic treatment of which 27% were antidepressants. Conclusion: The cosmetic surgery population presents a significant state of psychological vulnerability. (C) 2001 European Association for Cranio-Maxillofacial Surgery. [References: 17]

1999

AZAIS F., GRANGER B., DEBRAY Q., DUCROIX C.

Cognitive and emotional approach to assertiveness.

Encephale, 25 (4), 353-357, 1999

(Services cités : Psychiatrie Adulte)

Assertiveness is an individual function which allows adaptation to social interaction. It needs an heterogeneous psychological processus using behavioral, cognitive and emotional components in

its expression. Dysfunction in assertiveness contributes to anxious, depressive and personality disorders, representing a frequent impairment for patients. Assertiveness was measured in a population of patients with anxious disorders (n = 33) without concomitant major depression. Rathus Assertiveness Schedule was used for the clinical evaluation, Beck Depression Inventory, Spielberger State-Trait Anxiety Inventory and Coopersmith Inventory was also used for clinical measure of depression, anxiety and self-esteem. Global score to Rathus Assertiveness, correlated no specifically with all the others emotional factors. This multidimensional function would benefit to a more discriminant approach, measuring first behavioral and cognitive skills employed in social adaptation and secondly the emotional component of the processus.

GRANGER B.

The discovery of haloperidol.

Encephale, 25 (1), 59-66, 1999

(Services cités : Psychiatrie Adulte)

Haloperidol was synthesized on the 11th of February 1958 by Bert Hermans at the Janssen Laboratories, Beerse, Belgium. Simple but ingenious methods of animal pharmacology suggested to Paul Janssen and his colleagues that this butyrophenone derivative, called R1625, then halop-peridol, would be of great interest: qualitatively, the pharmacological action of R1625 was similar to chlorpromazine, but R1625 was very more powerful since it produced effects with much smaller doses than chlorpromazine. Soon after the synthesis and animal studies, haloperidol was administered in humans by Divry, Bobon et Collard, psychiatrists at the Liege Hospital. The first clinical publication, on the 28th of October, 1958, described the effects of haloperidol in agitation states. The subsequent clinical studies, including those of the prestigious French school of Sainte-Anne hospital, confirmed that haloperidol belongs to the pharmacological family of neuroleptics, as it was defined by J. Delay and P. Deniker in 1955. These clinical studies demonstrated also that haloperidol was particularly active against delusions and hallucinations. Numbers of chronically inpatients were able to leave hospital and to live home thanks to this new drug, which remains one of the more prescribed neuroleptics 40 years after its discovery.