

La dioxis (*stalking*)

Une nouvelle forme de harcèlement, cause de stress, trauma et PTSD

Marc Bourgeois

Résumé

Une nouvelle forme de harcèlement vient d'être cliniquement définie au plan clinique, psychopathologique et légal. Après le harcèlement sexuel et le harcèlement moral, il s'agit de la dioxis, terme que nous proposons comme traduction de *stalking* (traque), qui désigne un harcèlement persécutif de surveillance, de filature et d'imposition de communications inappropriées et non désirées (téléphone, courrier, etc.) assiégeant la victime et faisant naître un sentiment chronique d'angoisse, de persécution, d'insécurité, de stress et de peur. Les victimes sont typiquement des personnes célèbres très en vue et médiatisées, ou plus souvent des personnes plus anonymes, généralement des femmes, poursuivies par d'anciens partenaires. Les conséquences psychopathologiques comportent de nombreux signes d'anxiété et du registre du PTSD avec une rétraction de la vie sociale. On connaît mieux maintenant, grâce aux quelques études empiriques, la personnalité des traqueurs et celle des victimes présentant des symptômes particulièrement marqués. Les traitements restent à être précisés et évalués.

Mots-clés

dioxis, harcèlement

Summary : Stalking (*dioxis*). A new form of harassment, inducing stress, trauma and PTSD

Stalking (*dioxis* for the french translation) is a new clinical form of harassment with clinical, psychopathological and legal definitions. It has similarities with sexual or moral harassment. Stalking consists in a prolonged behaviour of constant close watch over and attempts to impose inappropriate and undesired communications by mail, e-mail, telephone, postal parcels or even threats, etc. The victims are celebrities (movies and TV stars, politicians, rich people, etc.) or more often anonymous persons, usually divorced women, harassed by their previous lovers or partners. Stalking behaviour induces chronic stress, anxiety, symptoms of PTSD and a withdrawal from social life. Some empirical and epidemiological studies show that this stalking behaviour seems to be increasing. There is a better knowledge of the stalkers and their victims. Treatment protocols are still to be designed and assessed.

Key words

stalking, harassment

Détruire l'enfant

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Résumé

Dès le moment de la conception, la destruction d'un enfant peut prendre de multiples formes. Tout être humain dès sa conception ne doit sa vie qu'au désir de ses parents. Ce désir peut être réduit à la seule satisfaction parentale : l'enfant est possédé. La mise au monde peut n'être qu'une reproduction des géniteurs. La mère peut défaillir à sa mission d'individualisation. L'inceste est une opération de dégénération, la pédophilie une recherche de consommation d'enfants. L'inceste, plus précisément, est semence de tout génocide.

Mots-clés

enfant, eugénisme, filiation, pédophilie, inceste.

Summary : Destroying the child

From the moment of the conception, the destruction of a child can take multiple forms. From conception, every human being owes his or her life to the will of their parents. Such desire can be reduced to the parents' sole satisfaction: the child is the parents' possession. Bringing a child into the world can be in some cases only a way for the parents to reproduce themselves. The mother can fail in her mission of individualization. Incest is an act of degeneration and pedophilia the quest for consuming children. Incest is more particularly the seed of every genocide.

Key words

child, eugenics, filiation, pedophilia, incest.

Plans d'urgence hospitaliers

Le plan MASH et l'afflux massif de victimes

François Ducrocq, Guillaume Vaiva, Sylvie Molenda, Patrick Goldstein

Résumé

Tout événement catastrophique à effet limité implique de nombreuses victimes. Pour leur assurer des soins adaptés et de qualité, et ce malgré le caractère exceptionnel de la situation, les établissements publics de santé ont élaboré des plans d'accueil des victimes encore appelés plans de Mise en Alerte des Services Hospitaliers ou plans MASH. Ces plans permettent aux centres hospitaliers une mise en œuvre rationnelle, efficace et rapide des moyens indispensables pour faire face à un afflux massif de victimes. Leur déclenchement est indépendant de la nature de l'événement causal, mais leurs modalités de déploiement relèvent de critères quantitatifs et qualitatifs relatifs au nombre de blessés, au type d'événement et à la situation géographique de l'hôpital. Leur mise en œuvre s'effectue sous la responsabilité d'une cellule de crise dirigée par le directeur de l'hôpital et composée de responsables de champs de compétences différents. Ses principales missions consistent à assurer la coordination entre les services techniques, administratifs et médicaux et à mettre en œuvre les moyens nécessaires pour gérer la crise. Enfin, d'un point de vue pratique, la prise en charge des victimes s'effectue en deux temps. On distingue d'abord une phase d'accueil et de tri, puis une phase de soin, de soutien et d'hébergement des blessés. À ce niveau, la prise en charge de la dimension psychologique individuelle, collective et sociale de la catastrophe joue un rôle important.

Mots-clés

catastrophe, afflux de victimes, plans de secours, psychotraumatologie.

Long summary : Hospitals plans of emergency. The "MASH" project and the massive flux of victims
Any catastrophic event with limited consequences implies a significant number of victims. Initially treated by the medical rescue teams, these victims are then repatriated towards the emergency services and are distributed, according to their pathology, in the various services of the hosting hospital. However, in normal operating condition, these services can accommodate and treat suitably only a small number of casualties. Therefore, a massive surge of victims is likely to cause a disorganization of the implied hospital structure. To counter that and to guarantee care of quality, the public establishments of health worked out plans for reception of the victims still called plans of setting in alarm of the wards or plans MASH. These plans allow the hospital to bring into action means to face a massive surge of victims in rational, effective and rapid ways. Their development is regulated by several texts of law, decrees and circulars. They define procedures which lead to a set of clear instructions immediately available and whose application is periodically tested. The release of MASH plans is independent of the nature of the causal event but their methods of deployment depend on quantitative and qualitative criteria relating to the number of casualties, the type of event and the geographical situation of the hospital. Their deployment is carried out under the responsibility of a crisis unit directed by the director of the hospital. This unit is made up of persons in charge of different fields of competences and is declined itself in several functional sub-units: Command, Action, Logistics, Information and Communication. Its principal missions consist in ensuring coordination between the engineering departments, the administrative departments and the medical services and putting into action the means necessary to manage the crisis. Lastly, from a practical point of view, the treatment of the victims is carried out in two times. You can distinguish initially a phase of reception and of sorting. At this level, the categorization of the victims is essential and distinguishes the UA (top priorities) : extreme urgency and first urgency; the UR (relative urgencies) : second and third urgency and the implied people; then a phase of care, of support and of lodging casualties. At this level, the psychosocial support plays an important part.

Short summary : Hospitals plans of emergency. The "MASH" project and the massive flux of victims
Any catastrophic event with limited consequences implies a lot of victims. In order to assure to them care of quality in spite of the exceptional nature of the situation, the public establishments of health

worked out plans for reception of the victims still called plans of setting in alarm of the wards or plans MASH. These plans allow the hospital to bring into action means to face a massive surge of victims in rational, effective and rapid ways. Their release is independent of the nature of the causal event but their methods of deployment depend on quantitative and qualitative criteria relating to the number of casualties, the type of event and the geographical situation of the hospital. Their deployment is carried out under the responsibility of crisis unit composed of persons in charge of different fields of competences and directed by the director of the hospital. Its principal missions consist in ensuring coordination between the engineering departments, the administrative departments and the medical services and putting into action the means necessary to manage the crisis. Lastly, from a practical point of view, the treatment of the victims is carried out in two times. You can distinguish initially a phase of reception and of sorting, and then a phase of care, of support and of lodging casualties. At this level, the psychosocial support plays an important part.

Key words

disaster, surge of victims, rescue plans, psychotraumatology

Deuil et traumatisme chez l'enfant et l'adolescent

Michel Grappe

Résumé

La mort d'un ami, d'un parent à la suite d'une longue maladie est un événement prévisible. L'issue fatale est en quelque sorte anticipée. Mais la mort peut survenir brutalement, parfois dans des circonstances horribles, et générer des "deuils traumatiques". Chez l'enfant, comme chez l'adulte, les phénomènes psychotraumatiques et ceux liés à la perte affective sont très différents. Nous avons mis en regard les deux sémiologies parce qu'elles orientent le travail thérapeutique dans des directions qui, dans ces cas, doivent être toutes les deux empruntées : l'élaboration du traumatisme (les cauchemars) et le travail de deuil (ambivalence, culpabilité, détachement). Ce dernier dépend de l'âge de l'enfant et de sa compréhension de ce que représente pour lui, à ce stade de sa maturation psychique, la mort d'un proche.

Mots-clés

enfant, adolescent, deuil, état de stress post-traumatique.

Summary : Bereavement and trauma in child and adolescent

The death of a relative, of a friend, following a long disease is an expected event, the end of life is anticipated. The death could be acute, unexpected for instance in an accident, a catastrophe, a crime; the circumstances of the death are traumatic for the relatives, the friends. The psychic reactions to the violent deaths are described "traumatic bereavements" in contrast with quiet death in the home, without mutilation, threat, horror. We propose a clinical assessment of "traumatic bereavements": Posttraumatic reactions and Bereavements reactions. The reaction after the lost of a loved one could be an acute grief, and in the evolution a chronic mourning. For children, the classification of the symptoms of psychic suffering (after the unexpected death of a relative) between acute grief and posttraumatic syndrome is a tool to organise the psychotherapy in two parts: for instance, working through the trauma (nightmares) and the mourning. For the child, we insist about his degree of comprehension of the death phenomena.

Key words.

child, adolescent, post-traumatic stress disorder, bereavement.

“ Je suis vivant. Non, tu es mort ”

L'écriture de la mort et du trauma dans l'œuvre de Maurice Blanchot

Éric Mèle

Résumé

Né en 1907, Maurice Blanchot, dont l'œuvre littéraire est immense et, qu'elle soit romanesque ou critique, placée sous le signe du secret, est une figure discrète mais capitale de la littérature du vingtième siècle. Le thème de la mort est omniprésent dans ses livres, l'espace que la mort occupe dans l'imaginaire de tout homme étant assimilé à l'espace littéraire lui-même, que Blanchot a baptisé du terme de "neutre". L'expérience traumatique qu'il a connue en 1944 sous la forme d'un simulacre d'exécution, très tardivement évoquée au sein de l'œuvre, éclaire celle-ci d'un jour nouveau, faisant mieux comprendre pourquoi la mort y est omniprésente, et comment l'écriture permet à l'écrivain de rejoindre la communauté des vivants dont la rencontre avec sa propre mort l'avait exclu.

Mots-clés

Maurice Blanchot, mort, littérature, expérience traumatique, répétition.

Summary : "I am alive. No, you are dead". Death and trauma in Maurice Blanchot's works

Born in 1907, Maurice Blanchot whose literary works are huge, whether they are novels or literary criticism, and which were always issued under the seal of secrecy, is a discreet but capital figure of the 20th century literature. The Death theme is omnipresent in his books; the space that Death occupies in every person's imagination is made similar to the literary space itself that Blanchot baptized under the term of "neutral". The trauma he experienced in 1944 after a mock execution and which is mentioned very late in his works throws a new light on them. It enables us to understand better why Death is so often omnipresent and how the act of writing allows the author to join the community of the living from which his meeting with his own death had excluded him.

Key words

Maurice Blanchot, Death, literature, trauma, repetition

Détresse péritraumatique après un accident grave de la circulation Valeur prédictive pour un PTSD à deux mois

Guillaume Vaiva, François Lebigot, Virginie Boss, François Ducrocq, Hélène Legru, Olivier Cottencin, Patrick Devos, Philippe Lestavel, Philippe Laffargue, Michel Goudemand

Résumé

Nous avons étudié de façon prospective différentes approches de la détresse péritraumatique, chez 123 sujets âgés de plus de 18 ans, victimes d'un accident de la circulation et nécessitant un séjour d'au moins 72 heures dans un service de traumatologie, en nous attachant à évaluer la relation entre les réactions émotionnelles immédiates et post-immédiates et la survenue d'un syndrome de répétition traumatique à deux mois. La survenue d'un PTSD était corrélée avec bon nombre d'éléments : certains items du critère A2 du DSM-IV, l'existence de troubles mnésiques par rapport à l'accident, l'existence d'un état de stress aigu initial. Nous pensons que l'état de stress aigu est plus à rapprocher de la notion de "détresse péritraumatique", dans un sens non spécifique par rapport au syndrome de répétition traumatique. Ainsi, l'état de stress aigu nous apparaît d'une nature en partie différente de la notion de PTSD. Il se présente comme un trouble anxieux dimensionnel, tandis que le PTSD serait une notion plus qualitative, catégorielle, à concevoir dans le champ des névroses. La notion francophone d'effroi s'est trouvée également très fortement corrélée à la survenue du PTSD ; surtout, elle est apparue extrêmement spécifique (sur 48 sujets, 47 présentaient un syndrome de répétition traumatique à deux mois). De plus, son apparent manque de sensibilité devait être fortement relativisé par le fait que 22 des 25 victimes développant un PTSD sans réaction initiale d'effroi présentaient d'importants troubles mnésiques par rapport aux circonstances de l'accident.

Mots-clés

détresse péritraumatique, état de stress aigu, PTSD, effroi

Long summary : Peritraumatic distress after a serious road traffic accident. Influences on traumatic re-experiencing at two months

An accurate definition of a traumatic event is difficult for a clinician. Most often, an event is considered as traumatic, in the light of the early reaction of the individual. These immediate and post-immediate reactions together, represent what we call "peritraumatic distress". There are several ways to appreciate the notion of "peritraumatic distress". For some, it only involves immediate emotional reactions. These are then evaluated semi-quantitatively (list of criteria, either DSM or other standardized tools), or qualitatively (the notion of fright). Others consider that peritraumatic distress also includes amnesic and dissociative post-immediate phenomena, or even the presence of an acute stress disorder in the days following the trauma. The aim of this study was to examine the different approaches to peritraumatic distress prospectively, by linking the influence of these immediate and post-immediate emotional reactions, to the development of traumatic re-experiencing, or even PTSD, at 2 months. We studied 123 male and female individuals, who were victims of a road traffic accident, and who subsequently required admission to the University Hospital of Lille Traumatology Centre for at least 72 hours. The accident involved at least one motor vehicle and all the victims were included in the study (drivers, passengers or pedestrians). Any individual with coma or head injury with loss of consciousness at the time of the crash was excluded, as were those with organic brain disease, dementia, alcohol abuse or addiction. The study was approved by the Hospital Ethical Committee and the patients included in the study gave their informed consent. The patients were examined using a clinical evaluation interview between the second and fifth days of hospitalisation, which included collection of general information (marriage status, employment, previous accidents etc.) and details of the circumstances of the accident (number of passengers, injuries, deaths, a description of the physical injuries, calculation of the Trauma Score, etc.). It was noted if the individual corresponded to the DSM-IV criteria for an "acute stress disorder" and in particular, if they had experienced a feeling of intense fear, of helplessness, or of horror, at the time of the accident. The interview allowed the individuals with signs of amnesia to be identified. We distinguished between the victims who had

minor signs of amnesia (a detail, the order of the events etc.), from those who had larger gaps (up to total amnesia of the accident). The individuals were asked to fill out a French version of Horowitz's self-assessment questionnaire (Impact Events Scale or IES), and we calculated the overall score, the intrusion subscore, and the avoidance subscore. Six weeks after the accident, the patients were recontacted by telephone and the questionnaire was completed during the phone call. The victims were aged between 18 and 74 years old (mean = 31.3, SD = 13.1). The mean severity of physical injuries was scored at 2.75 on a scale of 0 to 5 (SD = 0.8; SAMU Trauma Score). 29 individuals were driving their own car, 24 were passengers, 56 were motorcyclists, 10 were pedestrians and four were cyclists. Seventy individuals felt intense fear at the time of the accident, 40 felt helplessness and 15 experienced a feeling of horror. Fifty-six of all of the patients (50%) presented with signs of amnesia for the accident: 31 had amnesia of a single, very small detail, 25 of several aspects of the accident, or even total amnesia. There was no difference between the sexes, or for age. The memory disorders correlated with the intensity of the physical injuries (Trauma scores; $p = 0.026$, $t = 3.8$), with the presence of feeling fright at the time of accident ($p = 0.01$, $\text{Chi}^2 = 9.05$), and with the development of PTSD at 2 months ($p = 0.01$, $\text{Chi}^2 = 9.05$); we did not find any relationship with the presence of an acute stress state at day 5 ($p = 0.45$). Between day 2 and day 5, 15% of the victims ($n = 18$) presented with a complete acute stress state, according to the criteria of DSM-IV. 21% of the victims ($n = 26$) presented with a subclinical form. We did not note any difference with respect to the sex, age or socio-economic status. The number of cases of acute stress states increased in proportion to the number deaths that occurred during the accident, but was not influenced by the Trauma Score. The IES score correlated strongly with the presence of acute stress. There was a strong relationship between an "acute stress disorder" at day 5 and the development of PTSD at two months ($F = 17.3$; $p = 0.0002$). Two months after the accident, we observed 51% of patients with complete PTSD according to the criteria of DSM-IV ($n = 57$). 12% of the victims ($n = 15$) presented with a subclinical form. The initial IES score correlated strongly with the development of PTSD at two months. In our patients, the development of PTSD correlated with a large number of signs of peritraumatic distress : the elements in criterion A2 of DSM-IV, the presence of memory loss for the accident, and the presence of an initial acute stress disorder. The intensity of the correlation with the IES score, with the number of injured and dead during the accident, and with the immediate emotional reactions, makes us think that an acute stress state corresponds more with the notion of "peritraumatic distress", and should be non-specific with respect to traumatic re-experiencing. An acute stress disorder therefore seems to us be different from PTSD. It is a dimensional anxiety disorder, whereas PTSD is a more qualitative, categorical notion, which fits in with neuroses. In our study, 48 of the victims who corresponded to criterion A2 of DSM-IV for PTSD or ASD reported experiencing an immediate fright reaction, when faced with the real possibility of death, in particular their own death. Of these 48 victims, only one did not correspond to the criteria for PTSD at two months. A fright reaction occurred more frequently in the women ($p = 0.007$, $\text{Chi}^2 = 7.4$), correlated with the number of injured in the accident ($p = 0.032$, $t = 4.7$), with the number of deaths ($p = 0.03$, $t = 4.8$), but not with the severity of the physical injuries. Thirty-seven of the 44 individuals suffering from acute stress disorder, corresponded to criterion A2 of DSM-IV and 29 of them described a fright reaction. Forty-seven of the victims, who presented with complete or subclinical PTSD at two months, had experienced an initial fright reaction. Four individuals had developed PTSD (one complete, three subclinical), without any initial fright reaction or amnesia. The three types of immediate reactions described in criterion A2 of DSM-IV, do not seem to be equally relevant. Fear at the time of the accident does not seem to be a sufficient criterion in itself. Identification of the individuals who experienced fear, is to mix together those who were able to cope with this fear, and those who could not. Therefore, for serious road accident victims, and in accordance with other studies, the notion of fright appears to be more sensitive than intense fear, and a little more sensitive than helplessness. An initial feeling of fright seems to us to be an essential qualitative factor in the clinical description of psychological trauma. When it is absent, some victims suffered an acute stress disorder, but only one developed PTSD at two months. Fright has shown itself to be extremely specific in our study.

Short summary : Peritraumatic distress after a serious road traffic accident. Influences on traumatic re-experiencing at two months

We studied 123 male and female individuals, who were victims of a road traffic accident, and who consecutively required admission to the University Hospital of Lille Traumatology Centre for at least 72 hours. The aim of this study was to examine the different approaches to peritraumatic distress prospectively, by linking the influence of these immediate and post-immediate emotional reactions, to the development of traumatic re-experiencing, or even PTSD, at two months. The development of PTSD correlated with a large number of signs of peritraumatic distress: the elements in criterion A2 of DSM-IV, the presence of memory loss for the accident, and the presence of an initial acute stress disorder. The intensity of the correlation with the IES score, with the number of injured and dead during the accident, and with the immediate emotional reactions, makes us think that an acute stress state corresponds more with the notion of "peritraumatic distress", and should be non-specific with respect to traumatic re-experiencing. An acute stress disorder therefore seems to us to be different from PTSD. It is a dimensional anxiety disorder, whereas PTSD is a more qualitative, categorical notion, which fits in with neuroses. In our study, 48 of the victims who corresponded to criterion A2 of DSM-IV for PTSD or ASD reported experiencing an immediate fright reaction, when faced with the real possibility of death, in particular their own death. Of these 48 victims, only one did not correspond to the criteria for PTSD at two months. An initial feeling of fright seems to us to be an essential qualitative factor in the clinical description of psychological trauma. When it is absent, some victims suffered an acute stress disorder, but only one developed PTSD at two months. Fright has shown itself to be extremely specific in our study.

Key words

peritraumatic distress, acute stress disorder, PTSD, fright reaction

Abord thérapeutique des troubles psychotraumatiques Implication de l'entourage familial et extra-familial

Étienne Vermeiren

Résumé

L'implication de l'entourage familial et extra-familial constitue une ressource souvent méconnue dans l'abord thérapeutique des troubles psychotraumatiques. Différentes situations cliniques sont abordées : les familles dont un ou plusieurs membres souffrent de traumatisme psychique, les couples dont l'un des partenaires souffre de traumatisme psychique, les familles dont un membre décède brutalement, les familles entières touchées par un traumatisme, ainsi que les situations de traumatisme sur le lieu de travail. L'article étudie en quoi cette implication de l'entourage peut être un moteur de changement, mais aussi quelles sont les limites de ce type d'approche.

Mots-clés

traumatisme psychique, familles, entourage.

Summary : Therapeutic approach of psychotrauma: involvement of the family and extrafamily circle

We are often unaware of the use of the family and extrafamily circle in the therapeutic approach of psychotrauma. Various clinical situations are being dealt with: families in which one or more members suffer from psychotrauma; couples in which one partner suffers from psychotrauma; families in which one member suddenly dies; whole families affected by a traumatism as well as traumatisms at work. This article looks at how family circle involvement can cause things to change and the limits of such an approach.

Key words

psychotrauma, families, family circle.