Michel BERCLAZ
Psychologist-psychotherapist FSP,
Qualified in Emergency Psychology
and victim support
training consultant

PSYCHOSOCIAL AND SPIRITUAL SUPPORT DURING AND AFTER CRITICAL INCIDENTS

October 2009

CONTENT

WARNING 4
1. THE GENEVA INTERVENTION MODEL 7
1.1. Means of action 8
1.2. Types of action 8
1.3. The concept of psycho-social and spiritual support 9
1.4. Basic principles 11
2. STRESS 12
2.1. Generalities 12
2.2. Stress from a biological point of view 13
2.3. Stress from a psychological point of view 15
2.4. Stress from an epidemiological point of view 20
2.5. Severe Stress 21
2.6. Stress and Trauma 23
3. TRAUMA 24
3.1. History of trauma 24
3.2. Definition of trauma 28
3.3. PTSD : cognitive model and empirical data (Grazia Ceschi Phd) 33
3.4. Diagnoses 43
3.5. Types of reactions 47
3.6. Categories of reactions 48
4. FROM PREMORBIDITY TO RESILENCE 50
4.1. Concept of premorbidity 50
4.2. Personality traits and structures 51
4.3. Neurophysiological base of memory 52
5. RESILIENCE 56
5.5. Impact on the handling 59
5.6. Conclusions 61
6. FORMS OF INTERVENTIONS 62
6.1. Necessity of immediate and post-immediate psychosocial support 62
6.2. Different types of intervention 63
6.3. Immediate psychosocial and spiritual support 67
6.4. Defusing and debriefing 70
6.5. Objectives of intervention 76
6.6. Limited number of supportive sessions 83

7. PRACTICING PSYCHOLOGICAL DEBRIEFING WITH CHILDREN 88
7.1. Introduction 88
7.2. Psychotrauma in Children 89
7.3. Working with Children and Adolescents 90
7.4. Support for Parents 91
8. SPIRITUAL SUPPORT 97
8.1. Traumatic shock and spiritual support (Maurice Gardiol & Cosette Odier) 97
8.2. Of the legitimacy of spiritual support (Michel Berclaz) 100
9. PSYCHOSOCIAL RESPONSES TO CANADIAN DISASTERS 1979-2001: 103
9.1. Presentation Outline 103
9.2. Bring Families Together 104
9.3. Disaster Funds 106
9.4. Support Community Initiatives 107
9.5. Community-Based Response 107
9.6. Lessons Learned in Organizing a Disaster Psychosocial Response Team 108
9.7. Community Response Approach 109
9.8. Victim and Helper Profile : 112
10. OCCUPATIONAL HAZARDS AND SELFPROTECTION 116
10.1. Reactions in intervening professionals 116
10.1.1. Identification to the victim 117
10.1.2. Identification to the aggressor 117
10.2. Professional exhaustion : burnout 118
10.3. The mirror effect and triangulation 119
10.4. Dealing with stress 122
11. ANNEXES 129
10. BIBLIOGRAPHY 135

WARNING

Macro- and micro-social crises have been ever present throughout the history of mankind. Repeated traumas due to natural disasters (earthquake, volcanic eruption, hurricane, avalanche, flood, famine or epidemics) human error or recklessness (airplane accidents, train, wrecks, fire …) and deliberate acts resulting from the violence that lays rooted in human nature coupled with the complexities of human relationships (criminal assault, domestic violence, rape, torture, hostage taking, terrorism, battle, slaughter, annihilation or relocation of entire populations) are factors that have shaped our past as well as our present, both individually and collectively.

An intervention aimed at benefiting people rendered frail by events cannot be applied in all neutrality, void of presuppositions, ambitions (in the broadest sense) and ideologies. The support offered should enable the victims of crises to mobilise, individually and collectively, the resources that are their own, which they can discover through the events, their story, their individual energy and their concern and preoccupation of each other.

We do not seek to become predators of others' suffering, nor do we want to name them and in so doing stigmatise and appropriate them to then treat and disappear. In this vein, we refuse to approach the situation as scientists in a science where the victim is the sole object of our study and empirical knowledge (void of the subjectivity) as a precondition to the intervention in its context. The mediator should be an element that intervene at a given point in time and in history, preoccupied by the notion of the victim as subject, the consequences of the traumatised person and the intervention proposed. In all interventions he should keep in mind his future departure, his own absence. The mediator has to support and maintain confidence in the individual and collective resources of the people victimised.

Our aim is to find individual and group resources, to identify, validate and support them so that they become the driving force, the motor behind the reconstruction of the subjects and also their solidarity in crises situations. We believe that trauma victims do not exist in and of themselves, but that persons having been victims of a single event which, because of its own story, gives rise to traumatism. In this sense, all psychological support, immediate or deferred, individual or collective, aiming towards care, search of residual resources or the development of projects, should integrate the dimension of placing the individual victim of potentially traumatic event in their respective context and history. It is in this light that strength and meaning can be extracted from the traumatic event.

In this line of thought, all therapeutical projects must not keep as a priority the rules imposed on it by the collectivity in which it is going to occur. Every therapy imposes on he who applies it an ethic of transgression. The support should integrate the preoccupation of the ethics of relationships, search and resources within the context. Each mediator should be aware of the conception of an intervention, its function and duration but also the implication of his own daily interaction with the victims.

Dr Christian Petel

This manual is the fruit of a slow and progressive work, which started many years ago. At first, it was only a small handout, support for a conference in Neuchâtel as a part of a continuous training of the Swiss Police Institute. Progressively, it evolved over the course of scientifical and experimental contributions that were added to it. This document was brief, simple and practical. However, it appeared through evident force that speaking of relatively limited concepts, like trauma or the debriefing, without taking in consideration their specific history, the contexts in which they developed did not allow us to fully comprehend their meaning, at the certain risk of over-generalisation potentially prejudicial for the treatment beneficiaries.

In a similar way, this text had a sole ambition of offering a few general and practical lines of conduct for all the professionals likely to have worked with the psychological distress of people confronted to dramatic incidents. In this sense, it was meant to be neutral and a-conflictual. It was meant to keep itself from the grand allures, rhetorical and theoretical alike, that seem still as vain in the world of practice and real life situations. And yet, this same practical reality forced us to open our eyes and come out of a certain form of denial. Indeed, any undertaken process always relies on representations, targets an objective taking its source from a given belief and the presented behaviours fatally rely on an ideology. Any process, and in particular those hoping to bring support to people in distress, comes from a defined social mixing and produces its impact at the heart of this melting pot. In this sense, it is a political act. And yet, this political act can see its meaning completely corrupted depending on the ideology on which it depends. This is the warning Dr Petel issues in the above text:

No initiative, especially if it aims to help, targeting people weakened by their context, acts in neutrality, out of any presupposition, of any ambition (in the noble sense of the word), of any ideology.

In other words, what we are going to try and undertake or not is going to depend directly of the ideology on which we are going to rely and the philosophy that inhabits us. Moreover, any discovery, as scientific as it may seem, is still guided or tinted by that ideology, these representations or the pressures of a political movement.

Naturally, this document doesn't escape the rule. The lectures of the theory as well as the products of our experience are inseparable of our histories and the context of our experiences. For this reason, the document starts with a presentation of the psychological support cell in or with which we take today more than twelve years of experience in immediate and post-immediate interventions beside victims. The reason that lead our group of psychologists to organise ourselves to meet people battling with dramatic events is probably associated with the fact that a number of people, in psychological or psychotherapeutical consultations, were victims, most a long time ago, sometimes sadly too long ago, and a very small number have had the chance to benefit from this support. The sentiment (maybe wrong) according to which an earlier action could have changed the course of things for the person, lead us to organise such system.

We must underline that this is in no way our bread-and-butter. Indeed, it appeared very quickly that it was impossible, and certainly not our desire, to create a new crenel for professionals living off interventions towards people in distress, such is the risk of creating a clientele and thus creating a dependence scheme. For this reason, the exercise of these interventions should keep a very particular space in our respective lives.

In spite of having tried at every moment to use the simplest terms and the most common vocabulary, one has to use professional vocabulary in many occasions. An interesting thing is, even for mental health professionals, this vocabulary isn't without its ambiguities. Indeed, the specialised words take their sources from fields that, even apparently close, rely on very different representations. Identical words are used in psychoanalysis, in psychology and in psychiatry although these terms have different meanings in these divided fields.

Thus, for example, the diagnostic of Post-traumatic stress disorder brings together the concepts of stress and trauma. However, both these words cover very distinct concepts and have origins so different that it is not reasonable to juxtapose them. We will timidly enter in this type of reflexion but after the presentation of the intervention cell, its method and ideology, we will present the definitions of stress and trauma.

As mentioned above, trauma cannot be defined without going through its history. Through Judith Herman's lecture, part of the concept's history will be visited leading to the definition of the diagnostic of PTSD. Then we will detail its form, the types and categories of reactions that it covers. We hope the reader will not go thinking that this diagnostic is to our satisfaction in any way. How could a diagnostic cover in a representative way the thickness and the particularity of every single experience of individual distress? Thus we will only contextualise it and compare it to other diagnostics, letting the reader develop his own thoughts on their differences and pertinence.

The first part of the document (chapters 1 to 4) will still concern the concepts deemed important, pre-morbidity and resilience. Pre-morbidity corresponds to existence, before the irruption of a potentially traumatising event, of a mental pathology or of a personality disorder that certain professionals feel is the principal source of durable feelings of pain. Resilience, yesterday very fashionable, remains an essential point to take on when working with human distress.

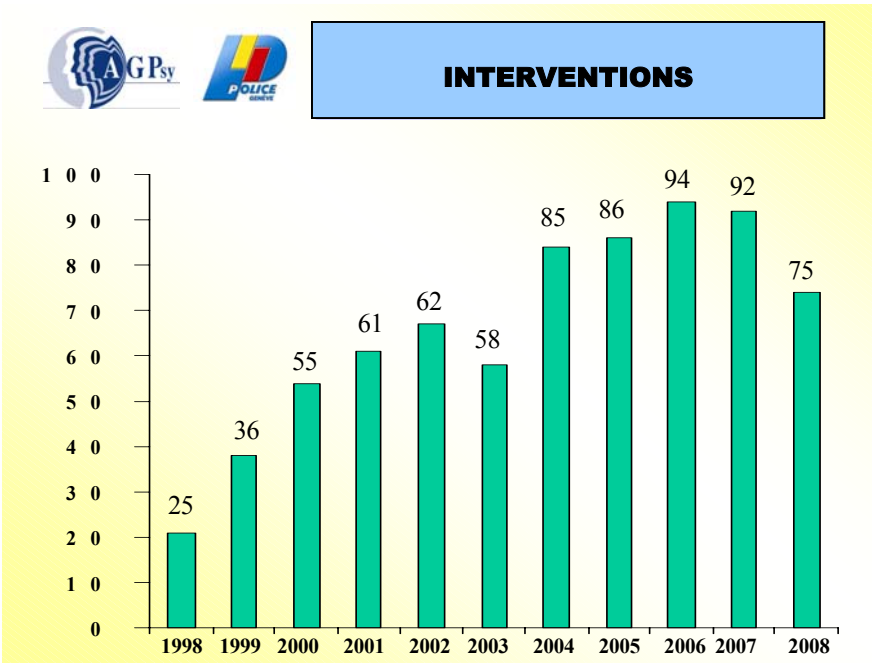
The second part of this work will concern the necessity and the pertinence of an intervention, the different forms of intervention and the description in more detail of certain of these and inherent particularities of interventions with child victims. We have tried to keep the simple, accessible and pragmatic character of this part. To achieve this, we have not entered in the debates concerning the effectiveness of the latter intervention form. The weight of these debates would be fatal to the objective of clarity and accessibility we are trying to achieve. This justifies our decision to extract the contradictory debates from this part of the work. However, in order not to betray our duty of intellectual rigor, the reader will find some abstracts in the annexes. The first extracts are drown from the excellent book by Raphaël and Wilson (2000), which suggests a well researched, and scientifically critical analysis of immediate and post-immediate interventions. The second is a slightly more recent article on the same subject. The readers will have the opportunity to discover the worries and preoccupations of the scientific world concerning the intervention towards victims … and develop by themselves a reflexion on the subject (ours appearing clearly enough throughout the document).

1. THE GENEVA INTERVENTION MODEL

Since 1996, the Canton of Geneva has developed a model of psychological support, described as psychosocial and spiritual (rather than medico-psychological), in the event of micro- or macro-social disasters. This model, well established among the professional networks in Geneva, advocates swift action, though at the lowest possible key, aimed at mobilising the residual resources of individuals, families, groups or communities. Its purpose is declaredly social, in that it attempts to accompany and comfort those who are distressed. However, it requires specific skills in emotional management on behalf of the professionals involved, specifically in terms of over-investment. The basic approach is "to do as little as possible, but all that is required".

Thus, the Police Force and the Psychologists' Association of Geneva joined forces and set up a psychological intervention team to handle crises or disaster situations. The team was established in 1996, to act in cases such as suicides, serious accidents, hold-ups, hostage takings, muggings (attacks), murders or other potentially traumatic situations. Since 2001 this same team is available to the general public and to corporations who may require its services under the title: AGPsy Psychological Action Team.

In the case of macro-social disasters, the team is called upon to work with other groups such as the Civil Security Psychological Action Group (GIPSY), the inter-confessional group for spiritual support, the specialised staff from the University Hospital of Geneva, or also the "debriefing teams" of professional groups (law enforcement: police, border police) or fire fighters. When such situations involve children, particularly during school time, the team defers to the medical-pedagogical services' (SMP) specialised action group. The team is also keen to cooperate with other persons, groups or structures, within or outside the canton, or even abroad.



As to October 2009 over 800 interventions are brought us to meet and accompany up to 3000 persons.

In 2007, we had 92 interventions concerning over 323 persons.

The year 2008 shows a decrease, potentially associated with the opening and development of the Social Samaritans in the canton (UMUS). They will receive demands that were previously made to the intervention cell.

1.1. Means of action

In the current contingency plans established for the Canton of Geneva, professional carers (psychologists, psychiatrists, nurses, etc.) take part in the civil protection brigades and receive training for major disaster scenarios, such as would trigger the OSIRIS (formally ISIS) canton-wide disaster plan. In such circumstances, the AGPsy-Police team is due to cooperate with all the above-mentioned groups, as well as with possible volunteers. However, it is often called in when smaller numbers of people are involved, for instance hostage situations or attacks. The cases in which the team intervenes are quite different from those requiring the psychiatrist who is on duty, as they would not *a priori* necessarily involve hospitalisation or even medication.

All the members of this team are FSP Psychologists (Swiss federation) and have undergone specialised training in relief psychology and in helping victims. Most of them are psychotherapists, acknowledged by the national professional organisations. They are on call 24 hours a day from the Geneva Police Headquarters, at the request of a police officer. Duty is detailed to two psychologists at a time, who are often accompanied by a trainee. The police team of psychologists is on the roster of duty. Interventions are not invoiced to the victims but remunerated by the police.

The psychological action team does not intervene directly with these professional groups (law enforcement: police, border police, or fire-fighters), but do participate in the training of these bodies' debriefing officers, given that the support is known to be more effective coming from a peer.

The professionals on the team undergo continuous training and provide teaching for organisations specialising in help to victims, as well as for those who may confront this type of situation on the front line (e.g. at the Geneva Airport).

1.2. Types of action

Such actions can take place immediately (within 20 minutes of the event) or later (the day after, for instance). The professional carers, after assessing the relevance of their action with the officer, get in touch with the persons involved. During this initial contact, they can observe the individual and collective resources of those concerned, based on the type of visible reactions and apparent resources. They undertake to mobilise the family and other support networks. Sometimes the carers provide information about reactions to stress: immediate, post-immediate and chronic; not only to those directly involved in the situation, but also to those indirectly concerned, like family members or friends, their supervisors for incidents taking place at work, for example. They may hand out to all those involved, a leaflet containing useful information to identify their own reactions and cope with them. This leaflet also includes a list of organisations, which may offer their legal, psychological, spiritual, administrative or financial assistance, as required, in the medium or long term. For the moment this document is available in French, English, German, Italian and Spanish. Many additional languages are now available through the RNAPU (National Net of Psychosocial Emergency).

The carers may organise, in the weeks following the event, one or two individual or group interviews, according to the situation and to needs. Carers may also ensure sporadic follow up action, maintaining contact by phone or other means over a period extending from two weeks to a few months. In cases which so require, victims can be referred to appropriate structures or organisations, particularly if therapy is necessary.

This team has intervened on numerous occasions, is situations such as accidents, suicides, murders in the presence of witnesses, drownings, fires and hostage takings. It has also been requested to mediate with violent deranged persons. Although calls are coming in with increased frequency, we expect the number of interventions to level off in the medium term. However, it would be interesting to compare the team's statistics with those of the police, to estimate the connection between the increase in the number of calls and that of incidents in general, to ascertain whether it is linked with a reflex to call in the team or rather to having created a need, for instance.

Let us point out that the greatest proportion of interventions is due to suicide situations. These are required either to deal with the shock of having witnessed a scene or discovered the corpse, or to compensate for the disintegration of the social fabric (absence of family, relatives or friends).

1.3. The concept of psycho-social and spiritual support

The scientific community now recognises that any person exposed to events during which other individuals may have died or been seriously affected in their psychological or physical integrity may suffer from reactions with potentially lasting consequences. These reactions may be somatic (physical), cognitive (intellectual), emotional or behavioural. They may be immediate or delayed.

These are recognised as natural reactions, and they usually wear off with time. However, they can become chronic. When these reactions are considered natural, this implies that the person cared for is, *a priori,* healthy, and not to be treated as a patient. We categorically reject the idea that only those persons suffering from pre-morbidity (a mental or personality disorder prior to the event) may develop some form of distress.

However, it must be stressed that the contemporary scientific community considers that, on the basis of data evidenced through Random Control Research (RCR), the effectiveness of immediate psychological action in whatever guise, can neither be confirmed nor definitively rejected. For example, B. Raphael and J. Wilson in their work “Psychological Debriefing. Theory, Practice and Evidence” (2000) consider that while debriefing techniques are born out by the good faith, the willingness and the theoretical work of their advocates, they are far from being substantiated by systematic hypotheses based on proven scientific data corroborated by empirical studies conducted according to tested methodologies. But, as in the process of any scientific development, only the results of systematic research will determine which supportive techniques are advisable in a given situation. Clearly, as immediate and post-immediate psychological support is still undergoing deep changes, likewise scientific methods will develop over time.

These authors conclude that the debate will undoubtedly persist. Let us hope however that it will lead to the acceptance of the methodological difficulties, of the limitations, as well as the positive and negative effects, and to the recognition of sound basic precautions. For instance, it would seem that one cannot claim to prevent a post-traumatic stress disorder. This may well prove to be the case, but systematic research is required to establish that fact. Ultimately, the discussion refers as much to science and its interpretations as it does to the opinion of the scientists/researchers. Hence, the theories underlying debriefing as well as other means of action require further clarification. We must reach a much clearer understanding and more accurate definitions of the social context, the concept of stress, what stress factors are, psychological adjustment, the phenomenology of neuropsychological reactions, and the intricate links between these various elements.

Above all however, the authors cast no doubt on the good faith and good will of professional carers. An altruistic drive impels them to try to support people experiencing potentially traumatic events. Perhaps we should strive to draw a starker distinction between altruistically driven support and debriefing, insofar as there is presumably a wide variety of other forms of intervention such as: relief psychological support, education/training, information, support groups, focused consultations, practical help, *inter alia.*

Indeed, this is what we have drawn from our experience in the field. In other words, intervening amid persons confronting a potentially traumatic situation is first and foremost a social act ; a simple desire to extend comfort derived from a basic feeling of human concern. Sometimes, it is quite simply a need to fill in for the impoverished social fabric, when those involved cannot turn to their families or friends. It is at that moment of initial contact that the carer can decide what type of support is required; the solution can, in no case, be standardised. The aim is simply to accompany the person in the early stages of recovery.

The person in a state of shock and distress is taken in by the carer with whatever reactions he or she may be having. The carer sees to this person without judgment or fear, with no obligation to talk either. Victims of attacks, those who were close or related to a person who died suddenly, those who survive an accident, or others who are distressed, run the risk of withdrawing into themselves, of no longer being able to give their lives a sense of direction, of being unable to involve themselves in the present, and ultimately of remaining mentally paralysed, emotionally frozen in reliving the traumatic event.

The deep psychological upheaval resulting from such an experience can be diminished if the persons are sheltered form too many additional stimulations, are informed of the circumstances of the tragedy, are listened to in expressing their distress, anger or impotence, are kept busy as much as possible, and are reassured about the volatility of their future reactions, which will often seem quite out of character. Yet the human and relational aspect of this action is pivotal since the carer will often be one of the first (if not the first) that the victim will have to face. This is a great responsibility since what is at stake is maintaining a link with the rest of humanity, opening a window on to the future, and helping these persons to invest in life despite their suffering. Hence the difficulties involved in the spiritual side of these actions. There is indeed a great danger of causing another trauma by adopting an attitude that is overly directive or not respectful enough.

Often, in the work with the victims' families, the process undertaken is essentially one of mourning. It involves accepting and assimilating the moral suffering caused by the loss of a loved one, as well as adapting to the changes it implies, be it on an existential or spiritual level, or within the family, or even in social and economic terms.

The role of accompanying carer, though technically quite simple, is particularly complicated from a relational standpoint. It is a matter of offering a calm and comforting presence, of gathering and disseminating clear and accurate information as frequently as possible and of guiding those concerned through procedures and through their individual processes. But more than anything else what matters is to stimulate their own capacity to cope and to bring them, for instance, to resort to their own individual, family, social, confessional resources. One of the main stumbling blocs in the difficulties of adapting is the risk of falling either into dependency or into isolation. To avoid this situation, to the extent possible, we recommend an approach in which the support provided is a discrete, albeit slightly aloof, presence.

Thus, the aim is to be available, while fostering in every possible instance independent action, individual decisions, relations amongst peers (in this case among families experiencing the same tragedy). For the accompanying carer, however, this aloofness is especially difficult to maintain. Indeed, the obvious distress of the families, their sense of impotence, and in particular our own sense of impotence, most often leads to hyperactive behaviour. As there is nothing to say (what can one say in such circumstances?) it is extremely difficult to avoid "doing". Then the risk lies in "overdoing", of acting instead of the families… and thus inevitably placing them gradually in a dependent relation, and thereby inescapably delaying the activation of their capacity to adapt. While clearly, the families very often greatly appreciate this unexpected help and care, we feel that in the medium term they will be more of a hindrance. From this angle, the accompanying carer has to face a true dilemma: to be liked by the family and receive the expressions of their gratitude, or to be effective in assisting their recovery.

Finally, yet another risk appears to further jeopardise the work of the accompanying carer. And that is the process of identification. Indeed, it is frequently noted to what extent the carer can feel "like" a member of the affected family. Feel the same emotions, for example: sadness, distress, anger, hostility, impotence, the need for recognition or confusion. Sound training would seem to enable us to detect the evidence of this process in ourselves. Such mirrored reactions, sharing of common feelings, this "emotional sponge" effect so to speak, are likely to produce "reactions" from the carer which may be inappropriate. For example, engage in conflict with this or that given group, take sides for these or those, to be "with" the families "on their side", demand recognition for our work or for our own suffering, etc. These are our own reactions to suffering, and as such are perfectly natural. Nevertheless, we must adopt a more appropriate stance, ensuring a higher standard of work, greater efficiency and more harmonious relations, which will be more liable to induce the recovery of all concerned.

1.4. Basic principles

Depending on these considerations, the Swiss Federation of Psychologists, in collaboration with the National Network of Support in the case of Catastrophe (RNAPU), recognises the principle that any person exposed to a potentially traumatising event can present psychic reactions likely to scar someone on a long period of time. By traumatising, we mean an event during which the individuals may have died or been critically affected in their psychological or physical integrity, even likely to cause a particularly affecting change in the life of the person, bringing unpleasant and durable consequences, leading to an Adjustment Disorder. This can result from human behaviour or natural causes, and can have micro-social (a small number of people) or macro-social (a large number of people are affected) extent.

The reactions of victims are considered here to be direct consequences of an important stress factor, freezing horror or of persisting trauma. The latter constitute the primary and essential causal factor, without which the disorder would not have appeared. In this sense, even though the factors of psycho-social stress or vulnerability could precipitate the appearing of disorders or influence the clinical chart, according to us the notion of pre-morbidity is not an essential element.

From the observation of the existence of the suffering, and in order to bring support to the members of society as well as supervision during these dramatic situations, the FSP commits to offer people trained for emergency psychology to intervene for organisms in need. The FSP offers the following definition for emergency psychology:

Emergency psychology consists of accompanying and supporting the people affected as well as their family and friends circle immediately after an extraordinary and potentially traumatising event.

It intends to activate the necessary resources in order to reestablish a psychological and social wellbeing and contribute in this way to avoid, the best it can, the subsequent damages.

PHILOSOPHY

- ► the interventions in emergency psychology aim for a psychosocial (and spiritual) approach and are not psychotherapeutic actions ;
- ► the professionals that practice it know the basic principles of the interventions in the field ;
- ► they are capable of using the assimilated knowledge in a critical and flexible way ;
- ► they know their own limits and are aware of the consequences of trauma on themselves ;
- ► emergency psychology is exercised only by professionals who do not depend on it financially ;
- ► the approach aims for the acceptation of the reactions considered as natural ;
- ► the professional is present only for a certain laps of time, instead of offering himself as a resource, at first he aims to gather those of the person, and then those of the family and its collectivity ;
- ► the professional must develop an ethical reflection on his intervention. He must be able, for example, to refuse a mandate associated with the intention of an organism to get ride of its responsibility towards certain decisions and/or certain situations considered as socially incorrect.
- ► the approach is minimalist : do as less as possible, but all that is necessary. Offer a presence and grant a maximum of command and control to the person and his/her close circle.

.

2. STRESS

2.1. Generalities

From the beginning of the eighties, the world of employment presents a notable transformation, going from a social logic to a financial logic based on the maximisation of profitability on short term and a constant search for the reduction of costs.

This research for the reduction of costs implies a reduction of stocks, the maximal adjustment to the offer (implying an extreme flexibility, work on demand and overtime requiring an intense effort of adaptation from the employees part) and the reduction of personnel as well as the wage mass.

The researches show that not only the chain labour does not diminish but becomes more complex. The technological developments require the employee to constantly train for new skills.

The evolution of technology also produces an augmentation of the risks to which one can add a sense of growing responsibility although the participation to decisions, liberty of action and individual needs' attention diminish in a significant way.

These new forms of organisation of work from the US have already produced a rise of 30 percent in the health suffering inflicted on their personnel. The rise of constraints, pressures, the degradation of work conditions, the draining of the capacity to adapt and the generalisation of precariousness have a dramatic effect on the health of employees often synthesised by the term stress. However, behind the term stress, one must understand the following:

- overload
- overwork
- wear out
- intensification,
- harassment
- suffering
- somatic as well as psychological pathologies.

The risk, in the generic use of the term stress, is to dispossess the different actors from their field of action on the problem… or worse, as we will see later, to place the field of responsibility exclusively towards the employees taken individually. With the concept of stress we have, on a social level, the admitting of a problem on one hand and the observation of helplessness on the other.

We will analyse the concept of stress from the different fields, as to cover diverse representations:

- biology
- psychology
- epidemiology

2.2. Stress from a biological point of view

The term “stress” from the 1950s to today have gone from the research laboratories from which it came to nest in the common language. In its travel it has seen its meaning widen out progressively.

At the beginning of his reflection, in 1936, Canadian psychologist Hans Seyle defined stress as a person’s series of physiological reactions (the researches were then performed on rats) to an external factor. These reactions happened in three stages:

- alarm reaction (shock, flight and attack)
- the general adaptation syndrome (survival syndrome)
- the exhaustion period

The alarm reaction, associated to a adrenaline shock (but particularly a rush of noradrenalin), implies shock, attack or fleeing the scene for which a series of neuro-vegetative reactions are produced, like:

- rise of the blood pressure
- rise of the cardiac rhythm
- perspiration
- various muscular reactions
- draining of the energy reserves (glucose and fats)

The general syndrome of adaptation, is the second stage, consisting of an organisation of the defences enabling the management of the excesses from the alarm reaction. Associated to cortisol, situated between the psychological and the physical, it implies the memory and the anticipation skills. It allows:

- the reduction of the blood pressure
- the slowing of the cardiac rhythm
- the reduction of the draining of the energy reserves
- the reduction of the inflammatory reactions
- restore the organism

The exhaustion phase: the mechanisms of the adaptation phase can be insufficient, overwhelmed or exhausted. We then know the terminal stage, exhaustion:

When the rat is unable to adapt, it dies by hemorrhagic digestive ulceration. It can happen in a few hours.

In the case of people, it can happen in the form of various physical or psychological pathologies.

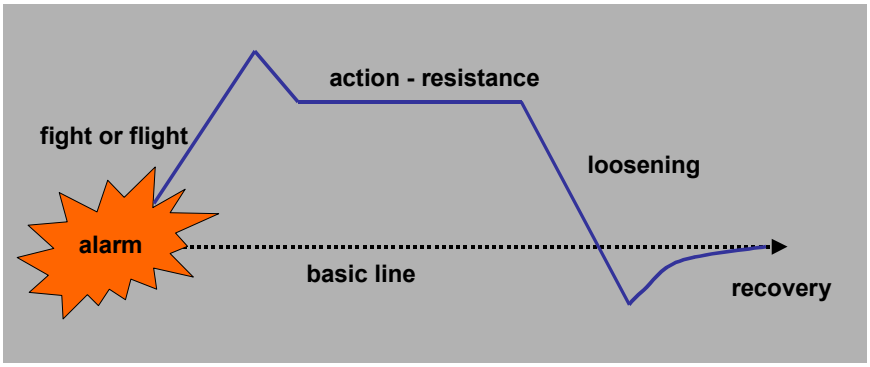
Thus, in the case of an adapted functioning, the phases of stress would then be:

Alarm: perception of danger, sudden realization of a grave event, rush of adrenalin/noradrenalin and choice of the reaction to undertake.

Action – resistance: the individual must carry out an action, his organism must face the situation, manage the alarm level, the effort, the consumption of energy, the inflammations, etc.

Loosening: corresponds to the effects at the end of an action phase. It is marked by more or less visible actions (trembling, nausea, fatigue, etc.)

Recovery: progressive return to normal



This phenomenon, we will see later, fills a necessary function to adaptability and to survival. It has a clearly positive reason to be. However, it will always present an energetic cost. Moreover, depending on the level of intensity, the repetition, the duration, the resources and the possibility of recovery, the stress is a source of pathology. Some of the risks or symptoms associated with stress are:

- cardio-vascular diseases
- obesity
- diabetes
- skin disorders
- ulcers
- inhibition of the immune system
- abuse of alcohol, tobacco, coffee, medication or drugs
- mental disorders
- insomnia, nightmares
- fatigue, apathy
- back or head pain
- sexual problems
- muscular tensions
- withdrawal, fear, anxiety
- irritability, aggressiveness and hostility
- incapacity to concentrate, memory loss
- negative self-image
- hyperactivity, rigid behaviour, stereotypes
- …

In fact, any disorder can be associated to stress. Indeed, a pathology, to be developed, needs 1) to be genetically possible, 2) a favourable position and 3) a trigger. In this sense, chronicle or repetitive stress is the most favourable field for the development of a disease and acute stress happen to be a rather effective trigger for any kind of trouble or disorder.

If at the beginning of Seyle's theory, stress corresponded strictly to a physiologic reaction due to an external factor, the concept progressively widened to cover all the reaction of an individual trying to adapt or re-adjust to external as well as internal pressures. These reactions then become of a **physiological, psychological and behavioural** order.

In this framework, we can understand that when facing an aggression, the organism tends to present the same general adaptation reaction, implementing a complex biological response qualified as "stress". The emotional reactions of stress, made of physiologic and psychological elements clearly have an adaptive function that enables to:

- **focus the attention on the danger situation**
- **mobilise the necessary energy to the evaluation and decision taking**
- **prepare for action (stupor, flight or attack).**

The emotions attached to it are inevitable and the cost of energy is important. The draining of the resources in energy can lead to overwhelming stress.

The work of biologists concern the adaptive reactions mobilised by the body towards any aggression. From their studies on animals, they describe precisely the physiological process implied in the defence and adaptation during an aggression.

Although they take little interest in stressing agents, biologists have nevertheless established that the animal doesn't respond solely by physiological reactions but also with behavioural reactions.

Notably, Henri Laborit had shown through his experiments confronting rats to electric shocks from the floor of their cage:

1. that a rat able to flee from the stressing agent did not develop deleterious suffering ;
2. two rats in the same cage seemed to be able to avoid the development of somatic pathologies by using their energy to activate, through a combat behaviour apparently harmless on health or relationship.

Following these experiments, but a lot later, Jay Weiss (in the seventies), showed that two rats in different cages, but submitted to the same source of electricity presented very different destinies depending on their possibility of having some active weight on their environment. That is to say, the rat that had a button in its cage or a wheel to turn likely to interrupt the electric shock, would not present any disorder while the other would develop a fatal pathology. And yet both would have received the same quantity of electric shocks.

Naturally, it is in no way adequate to transfer these results identically to humans. In particular, if the use of conflict is probably tried in a similar fashion with humans when facing a difficult contextual situation that we cannot flee, this defence mechanism often alters the relation and becomes a new source of stress. However, fleeing the scene (when possible) and the control and command of certain elements of the environment are clearly very efficient in the struggle against stress. In this sense, the biologists' work meets that of the psychologists.

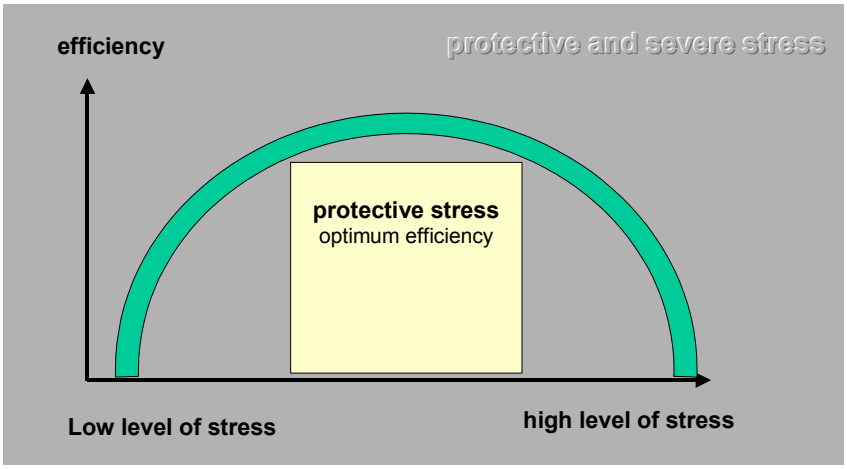
2.3. Stress from a psychological point of view

The psychologists have demonstrated that the emotional response is closely associated to the evaluation the individual makes of the situation. We are speaking of a appraisal, relying on the – completely subjective – measure of the relation between:

- the danger
- the needs
- the necessary energy
- the available resources
- the capacity to confront
- and the direct benefit as a co-lateral (success, social recognition, etc.)

As soon as we understand that the stress, contrary to general belief, is a reaction produced by nature, to allow the individual to confront the dangers and difficulties. A priori, instead of a problem, it is more of a necessary survival process. Under a certain threshold of stress, the subject lacking motivation, struggles to mobilise its resources, lacks attention and becomes bored. Unfortunately, when the situation endures too long, that the alarm is too strong or that the adaptive system is overwhelmed, what was a solution progressively becomes a problem and the subject suffers. For this very reason, one can talk of:

protective stress	**severe stress**
eustress	**distress**



We will note that as functional as stress may be, it is nearly always usury on a physical point of view. It exhausts and irritates the body, and on a medium or long term cause damages. It may be necessary to distinguish these terms between the basic motivation, the attentive wakefulness and the more "wearing" levels of stress? Moreover this scheme places boredom as the opposite of stress, when for some it could represent a high level of stress (one gets agitated or angry).

The effects among humans and communication:

is one of the fields most affected by stress, because everyone will react in a particular way, changing his/her usual behaviours.

Great types of reactions

- ► withdrawal
- ► maximal exteriorisation
- ► « oscilliations » between withdrawal on oneself and maximal exteriorisation : this includes mood swings sometimes incomprehensible for the person itself.

If the group is multicultural, it is essential to keep in mind that the capacity to « adapt » to the other will be reduced. Indeed, under stress, everyone will have a tendency to communicate more easily from his best integrated coding system, for example his mother tongue. The transmission of important information risks being affected by this and thus intensifying the sense of vulnerability of certain people.

Examples of the effects of stress on communication :

- ► mixed messages, unclear content
- ► inaccurate messages
- ► no messages
- ► inappropriate messages (personal content in professional documents)
- ► rumours and « gossip »
- ► tendency to criticism and complaints

As we have seen before, the concept of stress has gone from a physiological reaction provoked by an external agent, to all the physical, psychological and behavioural reactions aiming at the adaptation to internal and/or external pressures. Today, the concept has integrated the common vocabulary, and often points to the **stressing agent**. An event, a situation, a person or an object is perceived as the stressing element, creating a reaction of stress. Sometimes the element is intern, like a thought for example. It is then difficult to distinguish the concept of stress from that of anxiety.

Stress or anxiety: its levels and effects

levels	Effect on the field of perceptions	Effect on the attention capacity towards reality	Effect on the capacity to learn and adapt
low	The person is alert, sees, hears, understands more than usual.	Confronting the situation, capacity to synthesise Links between his behaviour and the environmental factors	The subject learns something about himself. Stimulated motivation. Observation, description, analysis, creation of significations and relationships with another person, integration and use of learning.
Moderate	The perceptive field is narrowed: the person sees, hears, doesn't understand as well, but can be led. The individual can remain more alert, more apt to concentrate on a specific element.	Attention diminishes; the individual doesn't see what happens at the periphery of his immediate objective.	Stimulated motivation Filtering of the stimuli **+**
High	The perceptive field is even more reduced, the person centres on one or more details.	The individual, due to his uneasiness, cannot take account of his environment. Tendencies to dissociation appear to prevent panic. Incapable of seeing what is happening. Incapable of evaluating the events in a realistic way	Filtering of the stimuli **++** The process of reflexion is hindered.
Panic	Terror sets in, the detail is extended to such a point it becomes exclusive. The details of the situation are distorted; the capacity to concentrate is disrupted. The individual can have the impression that his personality is disintegrating.		With or without well-developed capacities, the person will turn to immediate reduction of the anxiety through automatic behaviours, that do not require thought.

Under stress, the faculty to listen and hear are altered! When a group realises that the communication problems are linked to stress, it is essential that they take urgent measures, with the intention of reducing as fast as possible the intern tensions. Indeed, united, the group seems to better face adversity.

Stress et anxiety :

Anxiety is defined as: a great concern, a psychological state accompanied by excitation or on the contrary, inhibition, and including a feeling of stricture to the throat.

Anxiety is a state of anguish considered mostly in its psychological aspect.

In medical terms, it is a general uneasiness accompanied by a constriction of the epigastria and a continuous need to change position; on a moral standpoint, a painful and durable concern mostly due to uncertainty.

ANXIETY

Level of urgency, of importance, of gravity or of danger of the situation. (Perception – comprehension)	Subjective evaluation of his own skills: present health state, self-esteem, resources. Weight of the expectations, need to succeed.
Availability of operating adaptive behaviours giving an impression of command and control.	Apparent ability to control through other people involved in the situation, depending on their relation with the subject.

Enables the alert state of the individual and prepares to the action (defence, flight or fight). It enables the reducing of the perceptive field, which renders possible the focusing on the more important details of the situation.

CONCENTRATION AND PREPARATION FOR ACTION

ADAPTATION

If the person feel he/she doesn't control the situation anymore and that it cannot be controlled by a person in whom he/she trusts, the anxiety can:

Produces a flight or avoiding behaviour

Reducing of the perceptive and cognitive skills, bothers the subject.

UNADAPTIVE

Leads the person to become aggressive

ADAPTIVE … but probably anti-social

The more recent and developed researches seem to show that the study of stress implies the global consideration of this phenomenon in the complex interactions it can keep with emotions, our evaluation of the situation (appraisal) and the availability of our coping mechanism. In any case, it seems evident that the way with which we evaluate and plan the problem is much more important than the problem itself.

Terminology

Drown from : Longman Webster English College Dictionary (1984), Longman Group Limited, London.

Concern

An uneasy state marked by interest, uncertainty and apprehension. Concern, more intellectual and less emotional, expresses voluntary involvement arising from an absence of indifference.

Care

A cause for anxiety; someone or something that is an object of attention, anxiety or solicitude. Care, concern, solicitude, anxiety and worry are related adjectives that can describe a troubled or engrossed state of mind. Care implies involvement with what causes this because of responsibility or affection for others Anxiety stresses uncertainty and apprehension, even fear.

State of worry

Mental distress or agitation resulting from concern, usually for something impending or anticipated ; anxiety. Worry suggest persistent and nagging mental perturbation, which is often futile or unnecessary.

Fear

Unpleasant often strong emotion caused by anticipation or awareness of danger; an instance of the emotion, especially occurring as a result of a specified danger or un pleasant situation.

Fear, dread, fright, alarm, dismay, consternation, panic, terror, horror all express some degree of agitation in the face of danger. Fear is the most general term, and may be strong or week. Fright is usually short-lived agitation due to shock, while alarm is fright aroused by sudden realisation of imminent danger. Panic is unreasoning and overmastering fear which often leads to mindless flight or counterproductive activity. Horror adds the idea of abhorrence for what is feared, especially for what may be seen.

Anxiety

Apprehensive uneasiness of mind, usually over an impending or anticipated ill. An abnormal and overwhelming sense of apprehension and fear often associated with tension, fatigue and physical symptoms such as palpitations an breathlessness..

Anguish

Extreme physical pain or mental distress.

Terror

A state of intense fear. Terror is the strongest term, and suggests extreme fear which may paralyse or lead to panic. Unlike the other terms, it usually describes fear for one's own safety.

Horror

Intense fear, dread, or dismay, consternation. Horror adds the idea of abhorrence for what is feared, especially for what may be seen.

2.4. Stress from an epidemiological point of view

P. Daviezes (2003) explains that the epidemiological researches, until the eighties, have pointed out a series of factors associated to professional stress, for example:

- overwork
- temporal pressure
- bad work conditions
- excess / lack of responsibilities
- ambiguity and conflicts of roles
- uncertainty concerning the future
- excessive or insufficient promotions
- non participation to decisions

Over the course of the different publications, the list of stressing agents has become longer and longer, however without allowing the elaboration of a satisfying comprehension model. We will have to wait for R. Karasek for the development of researches to establish themselves on a generally accepted conceptual model and today based on four components in interaction:

COMPONENTS	DECISIVES
1) the demands of work However, the level of the standard does not suffice t explain the effects of work on one's behaviour an health. Indeed, to understand these effects, one mus add :	R Karasek explains that they are assessable in terms of : - quantity, - complexity, - Time restraint
2) the degree of autonomy of the employee The constraint produces an excitement, an unbalance If the subject has sufficient autonomy, the energ mobilized can find a way out in the search fc operational solutions. It contributes to the constructio of skills, to the development of the subject and to th preservation of his health.	In this model, the autonomy applies on two dimensions : - participation in decisions - the choice of operation modes and experimentation with new modes. He will prove that the association of strong standards and weak autonomy is correlated to psychological suffering and somatic pathologies.
3) social support Independently from the two first components, the lac of social support increases the manifestations c psychological suffering and certain somati pathologies. Isolation is a recognized factor c morbidity and mortality.	In 1990, R. Karasek and T Thoerell will add this component applying on two dimensions: - solidarity and support between peers, - technical support and the understanding of executives.
4) balance efforts – rewards Researches seem to prove that the feeling of absenc of reciprocity linked to the unbalance between these t elements, the lack of recognition, greatly increases th probability of cardiovascular pathologies as well a depressive manifestations.	J. Siegrist will finally complete the model with the evaluation of the relation between the effort provided and the rewards received. The contribution corresponds to: - the expectations of the hierarchy, - the expected performance by the employee. While the retribution is evaluated by: - the respect, - the status and - the financial gratifications.

Thus we can distinguish to kinds of stress following each other imperceptibly, but we can also define several categories of phenomenon or concepts associated with stress:

Protective stress	Severe stress
Basic stress	
Cumulative stress	
professional exhaustion (burnout)	
acute stress	
Post-traumatic stress	

Basic stress: it corresponds to the "basic line". Adaptation to life in a group, in a family, in a team as well as work situation involving a certain number of difficulties, of which we can find: integration to the group, accommodation to the style of leadership, professional adaptation, family vagaries, the lack of comfort. These efforts of adaptation constitute the basic stress. Even though it is variable from one person to another, all share the latter.

2.5. Severe Stress

Cumulative stress : contrary to traumatic stress is caused by a unique, sudden and violent situation. Cumulative stress is the result of a prolonged exposition to various and daily repeated aggressions. For example:

- family vagaries
- socio-economical difficulties
- climate of insecurity
- the events of life and changes in process
- felt frustrations

Amongst the events of life, we have, for example, the repetition of experiences with confrontation in critical situations. It seems that professionals involved daily in dramatic situations (firemen, policemen, customs officers, rescuers…) are better protected against traumatic reactions than the common citizen. These professionals learn to put up with these events, they have way to anticipate, the dramas and chaos of their everyday life, they have learnt the procedures enabling them to be functional even during emotional upheavals, they know how to "unplug" their conscious contact with their emotions and avoid the feeling of helplessness while carrying out their mission during an intervention. However, the repetition of confrontations to drama and distress, the creation of a number of "files" of events potentially traumatic regularly produce a fatigue or usury likely to lead them to react in a stronger way than usual in situations that could seem ordinary to them. We could even observe the development of a post-traumatic stress disorder, of which the process is associated with difficult personal experiences even though well controlled until then.

Concerning the scale table of social adjustment, the well-advised reader will easily pick up how much the value units, as well as the rank can seem subjective and poorly relevant. Authors, Holmes and Rahe, in 1967 tried to evaluate in a quantitative way the intensity of stress on a person, representing the average individual without taking account of the personal significance of the event on oneself. This scale of social adjustment relies on the *a priori* fact that the events of life, good or bad, demand a certain energy for adaptation. The study was done on the members of a boat, placed in the same experimental conditions (two months at sea). The results had shown that the individuals scoring 300 or over, in the six months preceding the evaluation, presented a higher rate of diseases than the others, and in a significant fashion.

Naturally, the study has garnered much controversy in particular concerning the high subjectivity caused by the individual variations. Later researches showed that changes in life are not that relevant to causing disorders, but indeed the deeply moving emotional component that they are likely to involve. The list only aims at showing how the cumulating of events that require adaptation, can elevate the basic line of stress.

Burnout: The reactions induced by professional exhaustion (burnout) are hard to distinguish from anxiety, depressive or traumatic disorders. However, professional exhaustion is generally associated with the loss of a certain number of illusions or ideals concerning, for example, the range of our work, our evaluation by others, as well as the institutional, hierarchic or generally social support.

Said otherwise, it would seem that the existing relation between the quantity of efforts produced and a series of disappointments and frustrations produce professional exhaustion. These disappointments seem related to the difference between the representation that the person had of his work and the reality of it. Disappointment felt by not being able to do as much and as well as the person would have wished. Frustration felt by not being able to do more, or not receiving/possessing the necessary means to fulfil the expected tasks in a satisfying manner. Frustration felt by receiving criticism or reprimands from colleagues and mostly superiors, by a lack of recognition by the institution and sometimes society in general. The signs of professional exhaustion are:

- decrease in energy, physical and psychological exhaustion
- anxiety and depressive manifestations
- difficulties to concentrate
- difficulties in taking decisions
- decrease in self-confidence, in others. Suspicion
- relationship difficulties with colleagues
- decrease in interest in socio-professional fields
- strong decrease in motivation for work
- absenteeism.

Immediate post-traumatic stress (acute stress reactions and acute stress disorder**):** corresponds to the immediate or post-immediate reactions likely to manifest during a confrontation with a critical, violent and sudden situation.

Post-traumatic stress: is in fact, a series of complications to immediate traumatic stress.

We will not enter the details of this concept. However it does not seem possible to treat stress without evoking traumatism. Yet, the link between both concepts in the same diagnostic of PTSD seems to produce a serious troubles within francophone psychiatrist circles.

2.6. Stress and Trauma

Indeed, associating two different terms defining distinct notions, moreover what they consider as an explanation prevailing a model of reaction to stress, induces a protection reaction in the French psychiatrists. Probably an intrapsychic model would suit them better. De Clercq and Dubois ("*Les traumatismes psychiques*", 2001) summarise this point of view in their first chapter :

- " … "PTSD" cannot claim to include all the many psychiatric and psychological reactions following a psychological trauma. Moreover, these anglo-saxon comprehensions present a certain degree of bias :
  - the evaluation of the prognostic according to psychometric tools, where PTSD's symptomatology prevails instead of social and domestic adaptation of the person. ";
  - the predominance of the "reaction to stress" model to explain the reaction of a person facing a critical event ;
  - stressing the grievousness of the circumstances of the event rather than the individual experience.

They believe that in the North-American conception, the reaction to stress fades as soon as the stressing agent disappears. Besides, they seem to resist the fact that highly menacing situations can be distressing for anybody. According to them, focusing on the impact of the event could tend to de-responsibilise the person.

According to these French psychiatrists, psychological trauma is clearly distinct from the concept of stress, mainly because the relation to danger is more crucial than the source of danger itself, but over all, because of the occurrence of the notion of terror or better express by "freezing horror" (effroi), far beyond fear, anxiety or stress. This notion of freezing horror describes the close personal encounter with actual death, which cannot be represented, or find any meaning, leading the person to relive the event as though it were continually recurring in the present.

In order to stress the component that is the individual facing the trauma, they suggest using the terms "traumatogenic" or "traumatogenical event" instead of "traumatic event". We recommend the expression of "potentially traumatic event" to describe this very individual aspect of the reactions, as well as "persons victim" rather than victims of survivors.

We do not share the impression that DSM-IV refers everything back to the notion of stress. Yet, if we also take stress and trauma as distinct notions, we must admit the existence of common physiological functions. Most of the mechanisms engaged in PTSD seem to develop from acute and chronic reactions to stress, where acute describes the extraordinary aspect of the experience overwhelming the ordinary human adaptations and chronic the fact that the reactions are indeed to continue long after the disappearance of the stressing agent or maybe the stressing agent is maintained by the distressing memory… or , as treated later, maintained by the events following the situation.

As we have seen, the concept of stress has gone from a physiological reaction caused by an external agent, to a group of physical, psychological and behavioural reactions aiming at the adaptation to internal and/or external pressures.

3. TRAUMA

3.1. History of trauma

To fully understand any subject, it must be placed in context, both historical as well and as political. For this short review of the concept of trauma, I have chosen three main sources:

- the very impressive research work of Dr. Louis Crocq (Crocq 1999 and De Clerc et Lebigot, 2001), based on classical literature as well as on the development of the concept in military psychiatry;
- the remarkable work of Judith Herman (1992) for its outstanding socio-political focus; and finally
- Dr. Bessel von der Kolk (2000) for its great quality of synthesis (probably inspired by Herman).

Indeed, in her edifying book, Dr. Herman explains the central dialectic of psychological trauma. She describes how the ordinary response to atrocities is to erase them from one's consciousness, certain violation of the social compact being too terrible to be spoken aloud. However, these atrocities refuse to be buried, the desire to deny them seems to be as strong as the conviction that denial does not work.

People who have survived atrocities often tell their stories in a highly emotional, contradictory, and fragmented manner which undermines their credibility and thereby serves the twin imperatives of truth-telling and secrecy. When the truth is finally recognized, survivors can begin their recovery. But far too often secrecy prevails, and the story of the traumatic event surfaces not as a verbal narrative but as a symptom.

The psychological distress symptoms of traumatized people simultaneously call attention to the existence of an unspeakable secret and deflect attention from it.

Because the traumatic syndromes share basic common features, Herman expects the recovery process to follow a common path, namely:

- establishing safety ;
- reconstructing the trauma story, and
- restoring the connection between survivors and their community.

The author stresses with deep insight, that the study of psychological trauma presents the curiosity of suffering from episodic amnesia: Periods of active investigation have alternated with periods of oblivion. Repeatedly in the past century, similar lines of enquiry have been taken up and abruptly abandoned, only to be rediscovered much later. Classic documents of fifty or one hundred years ago often read like contemporary works. Though the field has in fact an abundant and rich tradition, it has been periodically forgotten and must be periodically reclaimed.

According to Herman, this amnesia is neither the result of ordinary changes in fashion nor of episodic lack of interest. On the contrary, the subject provokes such intense controversy that it seems to become periodically anathema, its study leading into the realm of the unthinkable, raising the fundamental questions of faith and belief.

Dr. Louis Crocq searched through the classical literature and studied the evolution of the concept of trauma in military psychiatry. Among his numerous quotations, let us highlight the following:

- the historical account of a soldier at the battle of Marathon by Herodotus (History, book VI, around 450 BC);
- the platonician's myth of Soldier Er (in book X of The Republic, around 380 BC);
- Xenophon's dream (in Anabasis, around 380 BC);
- the knight Pierre de Bearn's case (in Froissard chronicle1325-1400);
- Lord Percy in Shakespeare (Henry IV);
- the distress of Pascal the philosopher following a coach incident (reported by Philippe Pinel in 1630);
- "the nostalgia" of the soldiers in the army of *Ancien Régime* (17th and 18th centuries) for whom the expression of fear was severely repressed. As well as the condition known as "soldier's heart" qualifying the neurovegetative manifestation of anxiety during the American Civil War);
- "le vent du boulet" acute state of stupor produced by fear among fighters having felt a projected object fly past them (expression attributed to Napoleonic army surgeons Desgenettes, Larrey and Percy and found again in the "Traité de Chirurgie de l'armée" by Legonest in 1872) ;
- the description of the Battle of Solferino by Henri Dunant (in "Un souvenir de Solferino,1862);
- "hysteria" (in the Traité Clinique et Thérapeutique de l'Hystérie", by Briquet, 1859), and later by Silas Weir Mitchell under "post-emotional hysteria" used to describe dissociative manifestations, and by: Charcot, Janet, Freud and Breuer, among the more well known;
- the concept of "psychical trauma" introduced in 1888 by Herman Oppenheim in "Traumatic neuroses" (Die Traumatische Neurosen). Based on labour accident and train crashes, he describes the effect of frozen horror on memory, anxiety, impairment in the emotional area and hypersensitivity.
- terms like "vent de l'obus", "obusite", "granatschockwishung" and "shell shock" will be used by military psychiatrists, along with the clinical variations.
- After "war anxiety", "war neurasthenia" and "war hysteria" the concept of "war neurosis" is developed by numerous authors among whom Ferenczi (1916) and Abraham (1918).
- From wars to battles, terms like "exhaustion", "free floating anxiety", "combat reaction", "combat fatigue", "war neurosis", "three days schizophrenia" have also been coined.
- Abraham Kardiner developed a different concept of war neurosis, insofar as he realised that the classical psychoanalytical defence mechanisms alone, could not explain the persistence of traumatic symptoms ("The Traumatic Neuroses of War", 1941, and "War Stress" and "Neurotic Illness" in 1947).
- The DSM nosographic system in its first edition (1952) proposed the diagnosis of "Gross Stress Reaction", to designate the psycho-traumatic state. It disappeared in the following edition (1968) only to appear again in the third revision (1980) under the now well-known "Post-Traumatic Stress Disorder".
- Finally, (I am adding) the ICD-10 in 1993 posits the diagnosis of "Acute Stress Reaction", "Post-Traumatic Stress Disorder" and "Enduring personality change after a catastrophic experience".

Let us follow Herman back into history and stop for a closer look. In 1881, Jean-Martin Charcot was the first to suggest that the symptoms of hysteria found their source in histories of trauma. By the mid-1890s, Pierre Janet, Sigmund Freud and Joseph Breuer had arrived at a similar formulation: hysteria was a condition produced by psychological trauma. The unbearable emotions associated with trauma induced an altered state of consciousness (named "dissociation" by Janet and "double consciousness" by Breuer and Freud) considered as similar to the hypnotic transe, a state which was to produce the hysterical symptoms.

If Janet thought that the tendency to dissociation was a sign of psychological weakness and suggestibility, both Breuer and Freud believed it could be found among "people of the clearest intellect, strongest will, greatest character, and highest critical power". However they all agreed on the fact that the somatic symptoms of hysteria were disguised representations of intensely distressing events banished from the memory.

Van der Kolk explained that Janet suggested that "vehement emotions" rising from the traumatic event would interfere not only with the integration of the overwhelming critical event itself, but later with the assimilation of new experiences. This phenomenon was understood as the splitting of traumatic memories (dissociation) and the strong reactions to reminders of the trauma with responses that had been relevant to the original threat, but currently without adaptive value, sapping the psychological energy of these persons, and causing a progressive decline in personal and occupational functions.

These investigators discovered that symptoms could find some relief when the traumatic memories, as well as the associated intense feelings, were recovered and put into words. This method became the basis of psychotherapy, name "psychological analysis" by Janet and "abreaction" or "catharsis" by Breuer and Freud, and will later be called "psycho-analysis" by Freud. Around 1896 Freud believed he had found the source of these trauma. In "Aetiology of Hysteria" he wrote: "I therefore put forward the thesis that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience, occurrences which belong to the earliest years of childhood, but which can be reproduced through the work of psycho-analysis in spite of the intervening decades. I believe that this is an important finding, the discovery of a caput Nili in neuropathology." Instead, this publication marked the end of research concerning child abuse, for within a year (probably due to the radical social implications) Freud privately repudiated his hypothesis.

In 1925 (in "Autobiographical Study") he wrote: "*I was at last obliged to recognised that these scenes of seduction had never taken place, and that they were only fantasies which my patients had made up*". Sexuality will remain at the centre of his research, but as a study of the internal vicissitudes of fantasy and desire, dissociated from the reality of experience. Finally, as Herman brilliantly concluded that for close to a century, these patients would again be ignored and silenced … Freud's discovery could not gain acceptance in the absence of a political and social context that would support the investigation of hysteria, wherever it might lead. Such a context had never existed in Vienna and was fast disappearing in France. Freud's rival Janet, who never abandoned his traumatic theory of hysteria and who never retreated from his hysterical patients, lived to see his works forgotten and his ideas neglected.

Over time, Freud's repudiation of the traumatic theory of hysteria did take on a peculiarly dogmatic quality. The man who had pursued the investigation the furthest and grasped its implications the most completely, retreated in later life into the most rigid denial … With a stubborn persistence that drove him into ever greater convolutions of theory, he insisted that women imagined and longed for the abusive sexual encounters of which they complained.

The reality of psychological trauma came up again with the shocking number of mental breakdown casualties during the First World War. Initially the symptoms were attributed to a physical cause (the concussive effects of exploding shells), but gradually the thesis of a psychological trauma could no longer be denied. However, as in the earlier debate on hysteria, medical controversy centered upon the moral character of the person, his vulnerability or his constitution. The British psychiatrist Lewis Yealland (Hysterical Disorders of Warfare, 1918) suggested a treatment based on shaming, threats and punishment. On the contrary, progressive medical authorities argued that combat neurosis was a natural psychiatric condition liable to appear in soldiers with high moral values.

Within a few years after the end of the war, medical interest in the subject faded once again only to be revived with the advent of the Second World War and the workframe of the American psychiatrist Abraham Kardiner ("The Traumatic Neuroses of War", 1941) and its revision by Herbert Spiegel (1947). For the first time it was acknowledged that any man could break down under fire and that psychiatric casualties were in direct proposition to the severity of combat conditions. The psychiatrists Roy Grinker and John Spiegel (1945) observed that the strongest protection against mental breakdown was the bond between the soldiers within a small unit, their morale and the relationship with the leader. The treatment strategies were based on brief interventions, as close as possible to the battle lines, and a rapid return to the fighting unit.

The role of altered states of consciousness in trauma was discovered again using hypnosis, narcosynthesis (dissociated state artificially induced by sodium methol) and "talking cure". Despite Kardiner and Spiegel's warning concerning the fact that a simple cathartic session was often insufficient by itself to integrate the traumatic experience, the new rapid treatment was considered highly successful. Let us stress that this controversy is rising again today concerning the debriefing method.

Finally, the political pressure from Viet Nam veterans' organisations and the women's movement resulted in a legal mandate which led to the PTSD diagnoses in 1980, edited by the American Psychiatric Association (DSM-III), demonstrating beyond any reasonable doubt its direct relationship to combat exposure. In attaining its formal recognition, it was also accepted that the most common post-traumatic disorder are not those of men in war but of women in civilian life. It has since become clear that the symptoms observed among the survivors of rape, domestic violence and incest are essentially identical to the one of war survivors.

DSM-III granted official recognition to the existence of a psychological distress through its PTSD diagnosis. Likewise, its revision (DSM-IIIR) proposed a new diagnosis of "Multiple Personality Disorder" covering the particular reactions among the victims of repeated abuse in childhood. However, this diagnosis disappeared in the following version (DSM-IV). In Switzerland, interest in the subject was revived when a law on aide to victims of delinquency was adopted in 1993 and enacted in 1994. One of its direct results was the Swiss Federation of Psychologists setting up specialised training in this field. Incidentally, the first generation of practitioners in the French-speaking part of Switzerland were mainly from Geneva. This group were to become the founders of the first Swiss psychological intervention team, made up exclusively of specially trained psychologists, who were on call by the local police force in critical small or large scale social incidents.

Although since 1998 approximately, the subject of psychological trauma – through work with victims of aggression - has become highly fashionable, we cannot fail to recognise that, notwithstanding, ghosts from the past have reappeared and seeds of discord have been sown. The notion of pre-morbidity is the present form of an ancient ghost and the seeds of discord in the field work with victims are taking root around the role and place of the various professionals intervening in such situations. The concept of pre-morbidity, which was already clearly identified in the background material will be further covered later, as will the contradictory debate regarding immediate and post-immediate interventions. As for the disagreement over the functions of various professionals, in various papers and books, the medical world seems to establish itself as the sole recipient of both knowledge and skills. On the subject of debriefing for instance, this stance is all the more surprising that physicians are claiming ownership over practices derived from the field -fire-fighters, police, military- who worked with such procedures naturally and informally, yet these are precisely the same groups who now find that they are being formally taught those very practices by the medical profession.

In a broader context, the whole issue might seem laughable if it entailed no danger. But, unfortunately, this is not so. Indeed, physicians, concerning the psyche, know essentially of illness (unlike psychologists who study both the normal functioning and psychological suffering) which tends to shape their outlook. Thus, traditional medicine might be inclined to “pathologise” individual reactions while dismissing the relation to the traumatic incident. This implies that present suffering will be seen only through the prism of past vicissitudes and individual vulnerabilities, thus leading to yet another victimisation of the person in distress. The preceding historical background has described this clearly at different stages of history. Now, we must not allow ourselves to be trapped into such unfortunate power games.

While it is recognised that to a large extent the trauma is due to a loss of control by an individual in a given situation, that persons’ recovery, or rather the assimilation of the event in that persons’ existence, shall depend on his/her regaining that control. Therefore, those who consider themselves imbued with unique knowledge and skills, are precisely those who may find it most difficult to mobilise the persons’ own resources. The suffering engendered by disasters, acts of terror or barbarism, is not a private matter concerning some, but rather a concern for all. This type of suffering tears asunder the fabric of human relations and can only find reparation by restoring links in the social tissue. The matter is broad, the answer to such distress cannot be medico-psychological; it must be (medical) psycho-social and spiritual.

3.2. Definition of trauma

Laplanche and Pontalis (*Vocabulaire de la psychanalyse, 1967)* give the following definition of trauma : "An event in an individual's life defined by its intensity, the individual's inability to react adequately, an upheaval with lasting pathological effects on his/her psychological organisation. In economic terms, a trauma is characterised by an excessive flow of excitement, in relation to the individual's tolerance and to his/her mental capacity to control and process this excitement…"

At the time, when psychoanalysis was formed, trauma was used mainly to qualify an event in the subject's personal history; an event that had a date and which is subjectively important on account of the painful feelings it may trigger. One cannot refer to traumatic events in absolute terms, disregarding the subject's own … "sensitivity". Strictly speaking, for a trauma to take place, and remaining as a "foreign body" in the subject's psyche, certain objective conditions need to be met. By their "very nature" certain events may indeed exclude a complete abreaction (…); but besides such extreme cases, a given event becomes traumatic because of its specific circumstances. These may be: the specific psychological condition the individual is in at the time of the event (Breuer's "hypnotic state"), or factual circumstances – social situation, demands of the task at hand – which impede or hamper an adequate reaction ("retention"), and last but not least, according to Freud, a psychological conflict which prevents an individual from consciously absorbing what is happening. Breuer and Freud further note that a series of events, the effects of which, taken individually would not cause a trauma, can add up.

Regarding this last point, the summation effect, this is precisely the phenomenon we would be tempted to call cumulative stress. Indeed, as we will see, it would appear that professional rescue workers seem more inclined to this type of reaction than to PTSD for example.

According to Judith Herman (1992) trauma is an affliction of the powerless, where not only the victim is rendered helpless but where the ordinary systems of care that give people a sense of control, connection and meaning is overwhelmed. She writes that traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence and death. They confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe. According to the Comprehensive Textbook of Psychiatry, the common denominator of psychological trauma is a feeling of intense fear, helplessness, loss of control, and threat of annihilation.

Dr Herman places the many symptoms of PTSD into three different categories : hyper arousal, intrusion and constriction.

Hyper arousal reflects the persistent expectation of danger ; the human system of self-preservation seems to go onto permanent alert, as if the danger might return at any moment… Patients suffer from a combination of generalised anxiety symptoms and specific fears. They do not have a normal "baseline" level of alert but relaxed attention. Instead, they have an elevated baseline of arousal : their bodies are always on the alert for danger.

Intrusion reflects the indelible imprint of the traumatic moment ; long after the danger is past, traumatized people relive the events as though it were continually recurring in the present… Trauma arrests the course of normal development by its repetitive intrusion into the survivor's life."

And because reliving such an experience provokes intense emotional distress, they tend desperately to avoid anything connected with the event, which results in a narrowing of consciousness, a withdrawal from engagement with others and an impoverished life.

Constriction reflects the numbing response of surrender ; when a person is completely powerless, and any form of resistance is futile, she may go into a state of surrender. The system of self-defence shuts down entirely. The helpless person escapes from her situation not by action in the real world but rather by altering her state of consciousness… These alterations of consciousness are at the heart of constriction or numbing, the third cardinal symptom of post-traumatic stress disorder. Sometimes situations of inescapable danger may evoke not only terror and rage but also, paradoxically, a state of detached calm, in which terror, rage, and pain dissolve. Events continue to register in awareness, but it is as though these events have been disconnected from their ordinary meanings. In fact, these constrictive symptoms also interfere with anticipation and planning, producing a foreshortened sense of the future.

The dialectic of trauma

Judith Herman stresses the existence of an oscillating rhythm produced by the opposition of the two psychological states associated with the contradictory responses of intrusion and constriction. She understand the alternation between these two extreme states as an attempt to find a satisfactory balance, but admits that balance is precisely what the traumatised person lacks. She/he is caught between the extremes of amnesia or of reliving the trauma, between floods of intense, overwhelming feeling and arid states of non feeling at all, between irritable, impulsive action and complete inhibition of action. This alternations represent indeed what Herman calls the dialectic of trauma, described as a potentially self-perpetuating process often mistaken for the individual's basic personality.

Because post-traumatic symptoms are so persistent and so wide-ranging, they may be mistaken for enduring characteristics of the victim's personality. This is a costly error, for the person with unrecognised post-traumatic stress disorder is condemned to a diminished life, tormented by memory and bounded by helplessness and fear…

Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis. The damage to relational life is not a secondary effect of trauma, as originally thought. Traumatic events have primary effects not only on the psychological structures of the self but also on the systems of attachment and meaning that link individual and community… Traumatic events destroy the victim's fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of relation.

Indeed, Herman explains that the acquisition of the sense of safety in the world, or basic trust finds its source in the earliest relationship with the first caretaker. She believes that this sense of trust sustains a person throughout the lifecycle and forms the basis of all systems of relationship and faith. In situation of terror, the sense of basic trust is deeply shattered : traumatised people feel utterly abandoned, utterly alone, cast out of the human and divine systems of care and protection that sustain life. Thereafter, a sense of alienation, of disconnection, pervades every relationship, from the most intimate familial bonds to the most abstract affiliations of community and religion.

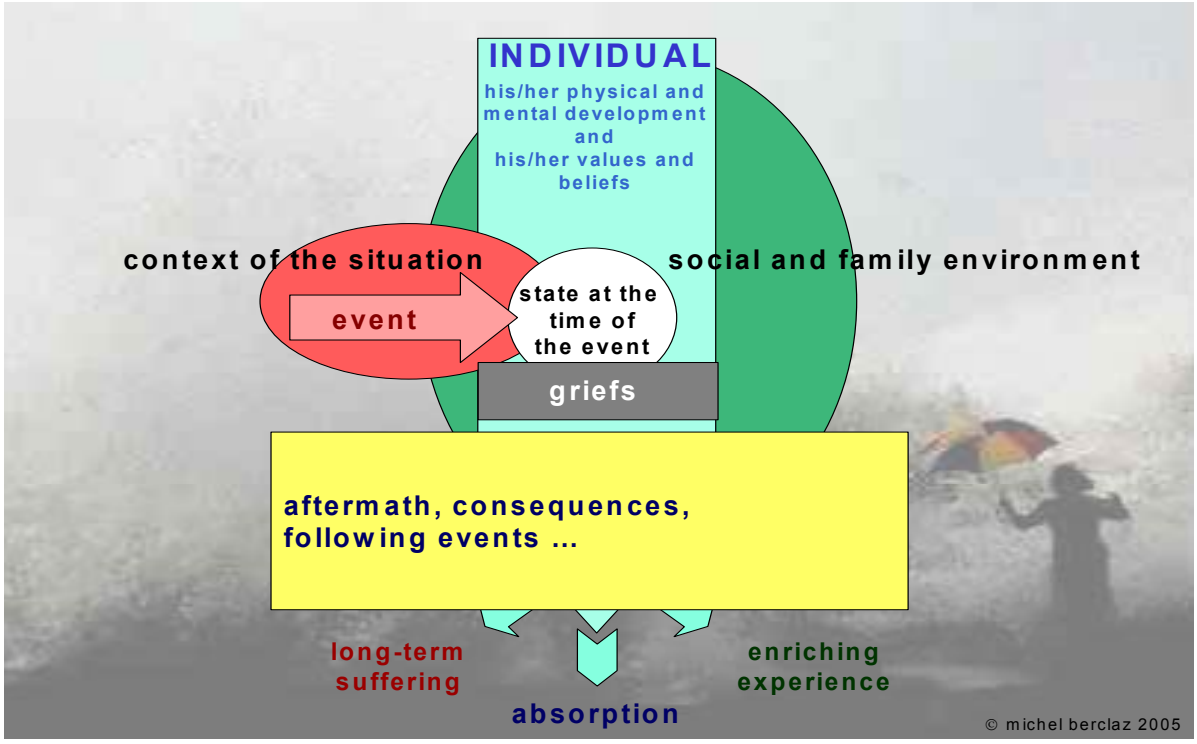
The reactions produced by these critical situations are reported under the diagnostics of: **acute stress reactions** (ICD-10) severe transitory disorder happening following a factor of exceptional physical or psychological stress and disappearing usually in a few hours or in a few days. **Acute stress disorder** (DSM-IV) on short or medium term is in fact a natural reaction to an exceptional situation and its disturbance lasts from 2 days to 4 weeks. Even though the intensity, the forms of the event and the individual responses vary greatly, often these reactions reduce progressively if the individual recognises and accepts his own emotions. Sometimes they persist, provoking: a **PTSD** (ICD-10 / DSM-IV) at medium and long term. IT corresponds to the pathological development of the state of acute stress when the latter has not been transcended or integrated by the subject. It can happen in a differed way, several months after the stress factor and become chronic. Depending on the situation, if the person was not present at the scene and that the aspect of “fright” is not present, when it is the implications of the event that cause the reactions, the latter are listed under: **Adjustment disorder** (ICD -10).

In more general terms, we may conclude that the term trauma is used to designate either an event, or the risk for the psychological economy caused by a given event or events, or by an individual's vulnerability. Freud, at different stages of the evolution of his theory, stressed the impact of a given critical situation (incest, war), while in other instances he emphasised the source of vulnerability in a person's psycho-emotional development, he even considered that fantasy substituted real events.

It is noteworthy that still today, this ambivalence prevails, seen by the different theories (whether dealing with diagnosis or treatment). Some attribute overriding importance to the power of events, while others see a person's vulnerability or pre-morbidity (presence of mental pathologies or of personality disorders prior to the event) as the pre-eminent factor. Our approach intends to be broader, insofar as we consider that the way in which an event is absorbed into one's life, one's history or psyche, depends on the result of the interaction of many individual elements. On that basis, it would be unrealistic to claim, at the time the event takes place that one can distinguish between those who will endure long suffering and those who will grow from the experience.

Thus, in my opinion, this lack of predictability is caused by the multiple interactions resulting from the variety of elements involved. Such various elements may, taken individually, amplify the traumatic effect or, on the contrary, play a part in protecting the individual or in helping to absorb the critical situation. Among these different elements, like Laplanche and Pontalis, let us consider the following :

- ► the very nature of the **event** : suddenness of its outbreak, threat to one's physical or mental integrity, the overwhelming flow of excitement it causes;
- ► **the degree of involvement** of the individual in the event, or his/her sensitivity to some of its characteristics;
- ► **the physical and mental condition** of the individual at the time of the event;
- ► **the individual skills** (defence mechanisms, excitement shields, resilience) or, on the opposite side, vulnerabilities developed through :
- ► the individual's psycho-emotional development, structure or personality disorders, but mainly his/her personal history, **the random course of existence** ;
- ► **the specific context of the event,** predictability of its occurrence, degree of preparedness, duration, etc. ;
- ► **the individual's social and family environment,** their ability to support the individual without making for dependency, or the opposite, contributing to his/her frailty and breakdown;
- ► the number and **gravity of grief** (objective or subjective) the individual has to face. It may be grief for the loss of irreplaceable loved-ones, in addition to the loss of physical or mental capacities (related to handicaps caused by the event), the loss of ideal representations of one-self (powerlessness during the event) or of society (loss of the sense of security), *inter alia.*



We have now arrived at the point where we must tackle the first quarrel concerning trauma: from the moment where it seems evident that several people involved in a same event do not present the same responses or reactions, that the majority of them will come out the other end relatively unscathed, how can we understand certain (a minority, from 12 to 25% depending on the studies) will live an intense and sometimes durable distress ? Must we admit the existence of a constitutional frailty, a vulnerability produced by history and the past traumas or must we think, as the diagnostic points out, that anyone can present intense and durable reactions ? In other words, must we choose between the predominance of environment, of the history or of the impact of the event ?

The reader will have understood, from the previous pages, that we can imagine that the multiplicity of possible answers is associated to the complex interaction of all the elements listed above, each having, depending on the individuals and the circumstances, a specific value.

Clinical vignette:

Lisa, at the beginning of his career had chosen a profession generally taken up by men. She had to put up with the gibes and mortifications of her colleagues and her director. She will one day decide to free herself from the restraints, to come to terms with herself. She will open a business of which she will be the owner and manager, thus becoming her own boss. This way, she would operate a form of reparation towards past painful experiences associated with her relationship with her father, for example. Autonomy, independence and control are the important values in her point of view, in consideration of her own history.

One day she will be victim of a hold-up. Threatened to death on several occasions, Lisa will be led to open her safe, and then be tied up. The man will also take the contents of her displays, the whole amounting to several hundred thousands of francs. Shocked by the event, she will consult a specialist. Her state will improve very slowly. Going back to her shop is a particularly painful experience. In fact, it is getting more and more difficult. As the days go by, she receives incomprehensible phone calls by clients and calls from always more insistent creditors. Bills are piling up. Getting back to work, which was already difficult because of the memories from the aggression, finally becomes impossible, until the day when her insurance company tells her that according to the speed of the event, it considers it shoplifting, which corresponds, based on the contract, to a little over 50’000 francs.

This decision will produce effects on a number of levels: it implies the non-recognition of the aggression itself, a trivialisation of the past experiences and, consequently, an implicit message concerning the proportion of her reactions. How can she react so strongly to such a common event ?

Moreover, since Lisa cannot reimburse her creditors, she is threatened by bankruptcy. She loses her trade and her chance at being independent. From the standpoint of her personal development and of her values, she must mourn the end of a part of her evolution. It is a dramatic step back. And it happens at a moment where she is extremely fragile, vulnerable, incapable of defending herself, or even react. She must consider finding a job, as an employee again and condemned to use part of her salary to repay her debts.

How could she consider having the strength to work in such conditions ?

Get better, recover, would imply having to work (again) in what she considers humiliating conditions (considering her history) and give her salary in a framework lived through as perfectly unjust and unacceptable. Consequently, how could she get better ?

What will she do with her fear due to her memories, of her constant fear and anger in this post-event context ?

Finally, is the potential chronicity of her reactions due to her history, to the fear of the confrontation with a violent death, or the future consequences of the decision made by her insurance company ?

3.3. PTSD : cognitive model and empirical data (Grazia Ceschi Phd)

Cognitive Psychopathology and Neuropsychology Unit
University de Geneva, Geneva, Switzerland.

The Post-Traumatic Stress Disorder (PTSD) has been introduced in the diagnostic systems in 1980 during the publication of the third version of the Diagnostic and Statistic Manual of Mental Disorders Manual (DSM-III; APA, 1980). Since then, the interest gathered for PTSD hasn't ceased to grow. As illustrated in Figure 1, in 25 years, the number of publications concerning this disorder has expanded greatly, going from a unique scientific article in 1980 to more than 800 articles a year in 2005.

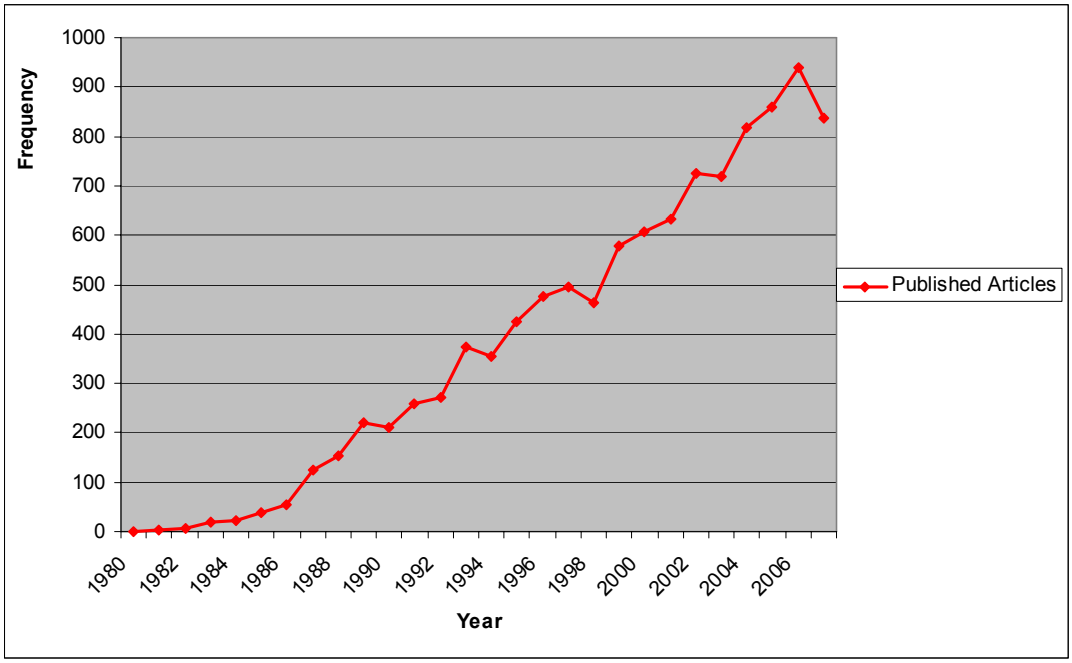


Figure 1: The number of scientific articles on PTSD published by year (source: PsycINFO, 2008; criterion of selection: "PTSD" in the title, abstract or keywords AND [year]).

This important and speedy cumulating of empirical data forces us to constantly revise our theoretical knowledge. Following this tendency, PTSD' cognitive models become more and more sophisticated and allow us to debrief and synthesize a number of complex phenomenon described in this literature.

The objective of this chapter is, mainly, to suggest a quick review of this literature through the presentation of two theoretical models: Ehlers and Clark's cognitive model (2000), and the dual representation in memory of trauma model by Brewin, Dalgleish and Joseph (1996). These two models are particularly influent in the clinical field. As a whole, PTSD is represented as a chronic disorder of the development of traumatic memory, of subjective judgment of trauma and its consequences, as well as the mechanisms of emotional regulation. After this presentation, our chapter will end with the presentation of a few clinical implications born from this approach and of which the scattering throughout the Anglophone community is beginning to modify the exercise of intervention. Our hope is that this chapter will contribute to giving the francophone public a more accessible understanding of this vast and influent literature normally only accessible in English language.

3.3.1 Cognitive models of PTSD

In compliance with the DSM-IV-TR (APA, 2003), PTSD characterizes itself by three groups of symptoms that one can observe in people having survived a traumatic event: (a) intrusive memories (f. ex., flashbacks, nightmares), (b) reactions of protection such as affective numbness, signs of amnesia and/or avoiding indications of recovering from the traumatic event, as well as (c) neuro-vegetative reactions of hyper vigilance and jolts. To diagnose PTSD, the DSM-IV-TR specifies that it is very important that these symptoms be observed long after the traumatic event (at least a month after) and that they are interfere with the functioning of the person in their daily life.

We currently know that in the immediate times following the sever trauma, a vast majority of the people present a part (at least) of the symptoms described above. However, only a small minority of them will continue to present the same symptoms on the long term. In other words, most people having been put through a potentially traumatizing event (estimate: 80%) present symptoms of stress in acute situations but will be able to benefit of a spontaneous recovery process. The latter will lead to a clear reduction of the symptoms in three to four weeks, and this without any specific care awarded. From this presently well acquired observation (Schnyder and al. 2001), any theory aiming at representing PTSD must, beforehand, explain why the majority of the people having survived a trauma spontaneously recover, while a minority continue to show signs of persisting psychological difficulties. One of the principle challenges of any PTSD model won't be to explain the symptoms of stress in acute phase, but their chronologisation once the trauma has passed.

In 2000, Ehlers and Clark suggested a cognitive model that took account the phenomenon. For the authors, PTSD manifests itself in individuals undertaking a treatment of the information relating to the trauma and/or its specific repercussions. This treatment produces a subjective sense of "present threat" independently of the presence or absence of a real threat. As illustrated in *Figure 2,* the model suggest that three cognitive processes contribute to the creation of this subjective sense of "present threat": (1) a dysfunctional cognitive appraisal of the trauma and its consequences, (2) a disturbance in the creation of the memory of the trauma and (3) control and suppression strategies aimed to reduce the threat and/or the symptoms.

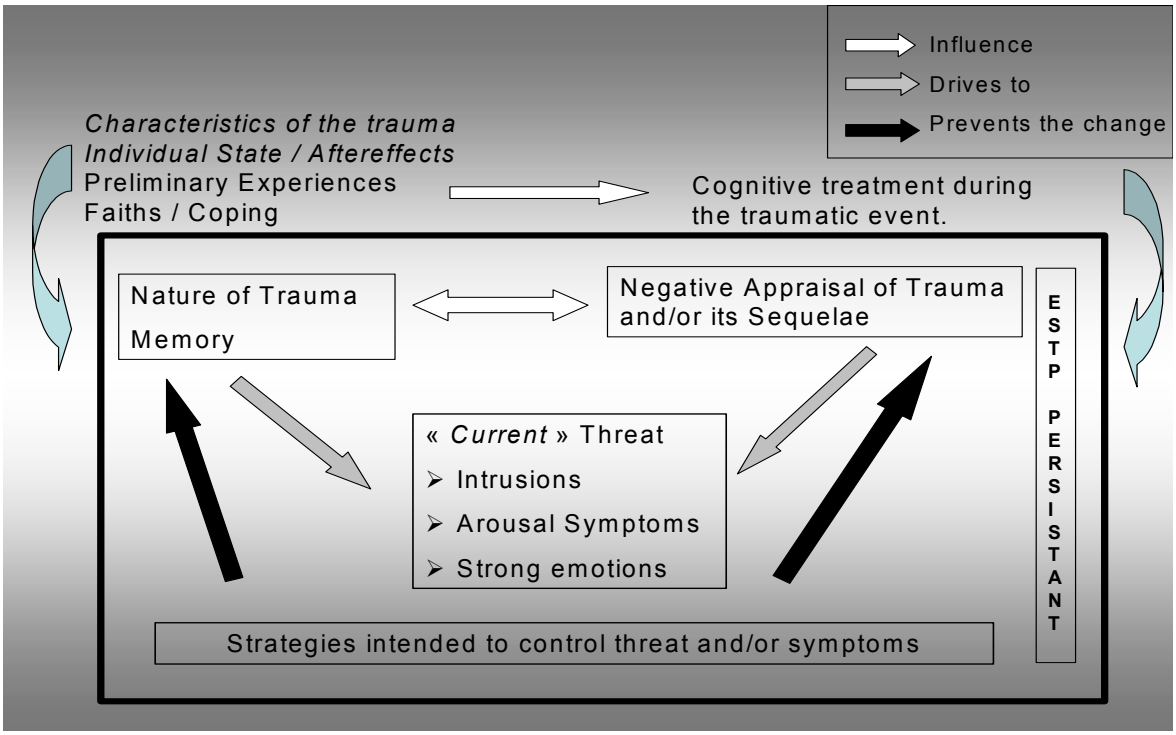


Figure 2 : Cognitive model of the PTSD by Ehlers and Clark (2000).

3.3.2. Disturbance in the creation of a memory of the trauma

In the case of PTSD, we can often observe two distinct and apparently contradictory memory phenomenon: (a) an over-memorisation of certain aspects of the trauma that, later, may appear in the field of conscience in an intrusive manner (i.g.., flashbacks), and (b) memory lapses for other aspects of the trauma (i.g., amnesia or disorganisation of several autobiographical aspects of the event).

As a whole, the researches relating the memory of the trauma suggest that both types of memories of the trauma are functionally and structurally distinct (for a detailed review of theses researches, see Ceschi & Van der Linden, 2008). Even though for certain authors this distinction is only due to the qualitative difference between the memories born from one memory process (Foa & Kozak, 1986), we presently postulate that autobiographical memories and intrusive memories both call on different memory processes (Bewin, Dalgleish & Joseph, 1996; Brewin, 2001). This position agrees with a certain number of cognitive models of memory that postulate, for example, that the existence of a perceptive memory system is independent of the ordinary autobiographical memory system (Tulving & Schacter, 1990).

Brewin and al. (1996) resume this reflexion in the frame of PTSD within the *dual representation of trauma in memory theory* (cf. Figure 3).

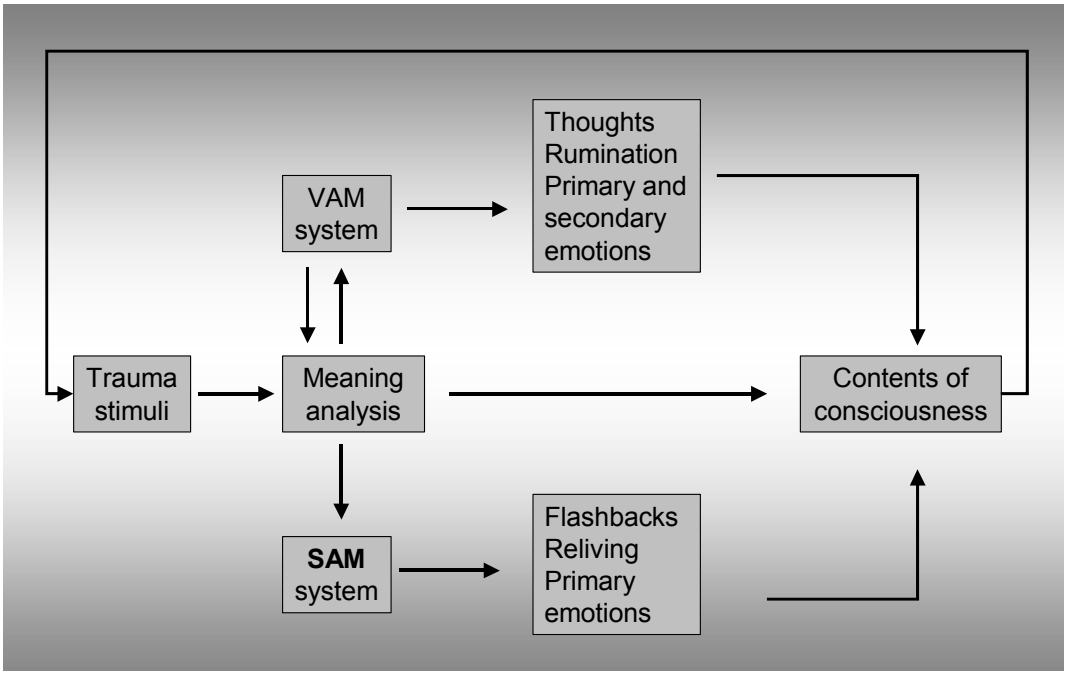


Figure 3: Dual representation of trauma in memory model (Brewin and al. 1996).

As illustrated in Figure 3, for these authors both systems continue to function in parallel, but at times one of them can gain the upper hand on the other. The system of “verbally accessible memory” (VAM) devotes itself to the treatment of memories of the trauma integrated in the autobiographical memory and accessible through a verbal, oral or written formulation. These representations of the trauma are integrated in the vast network of personal information that cover the past experiences, the present and the future of the person. They are the object of the voluntary recovery and their evocation can be communicated by others. However, these memories can only store a limited quantity of information. Indeed, only the information considered consciously is stocked. Thus, a distraction or a strong activation at the moment of the trauma (p. ex, associated to a peri-traumatic dissociation process) tend to considerably reduce the volume of information saved by the VAM.

On the contrary, researchers consider that flashbacks are the product of the “situationally accessible memory” system (SAM). This system is only accessible through situational clues – from the exterior or interior environment of the person – that activate the production of an intrusive memory in an involuntary manner (recovery indications). The Sam contains a wide ensemble of perceptive information, of low level of cognitive treatment, linked to the scene of the trauma (p. ex., noises, smells, etc.). Often, this information had not been considered fundamental during the traumatic event and, had not received the necessary attentive resources for an encoding in the VAM. The SAM also stores information relative to the physical response of the person, like for example the variations of the cardiac rhythm, the temperature or the pain. All this information results in vibrant “flashbacks”, rich in sensorial details and fundamentally rooted in the emotional experience. Of course, since the SAM does not use a verbal code, these memories are hard to communicate to others, as to oneself. Indeed, it is sometimes hard to give meaning to them, to understand what sets them in motion or to control them.

The dual representation model receives an indisputable support from the empirical data published as affective neurosciences. Thanks to a vast review of the literature, Brewin (2001) underlines the importance of the amygdale for the SAM and the hippocampus for the VAM.

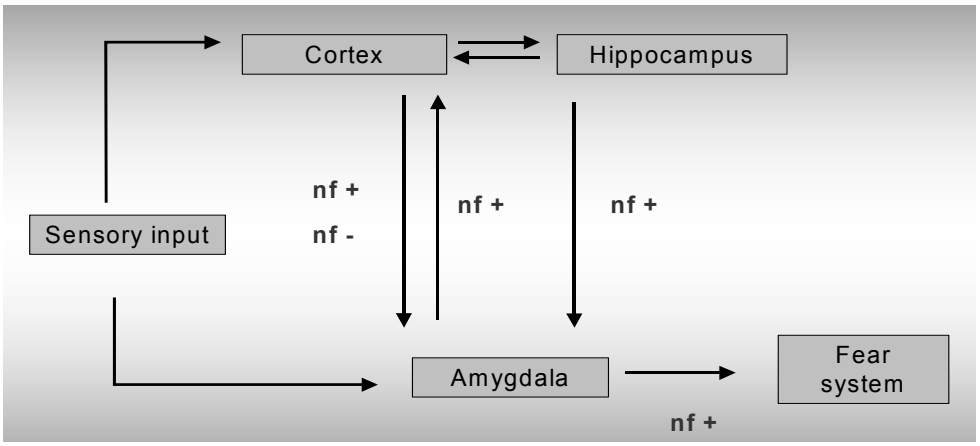


Figure 4 : Brain structures involved in the fear response. *Note* : nf + = activation nerve fiber; nf - = inhibition nerve fiber .

As indicated in Figure 4, we consider within the affective neurosciences that any sensorial input (i.g., a trauma) will be subject to a double encoding: one at an under-cortical level, quick and implicit, related to the tonsil (SAM) which produces responses of fear and intrusive memories ; the other at a more cortical level, slow and explicit, related to the hippocampus (VAM) which produces contextualized autobiographical memories. As indicated in Figure 4, these two systems maintain multiple mutual relationships of activation and/or inhibition. Without entering the details of this argumentation, it is interesting to signal here that stress exercises very different actions on the hippocampus (inhibition) and the tonsil (activation). Indeed, the reaction of stress produces a liberation of adrenaline and glucocorticoids. Adrenaline exercises an activating action on the tonsil, while the cortisol affects in an unfavourable way the functioning of the memory linked to the hippocampus (Nadel & Jacobs, 1998). This differential pattern of effects of stress on the circuits of memory consequently implies that the traumatic event can encourage the encoding by the SAM and impede on the declarative treatment of the VAM. This neurobiological prediction, globally corresponds to the “radiography” of the functioning of the memory of people suffering of PTSD: an over-memorisation of certain aspects that aren’t explicit of the trauma, they would appear in the form of flashbacks and/or physiological activation with no apparent cause, and an under-memorisation of a coherent narration of the trauma in the form of an autobiographical memory inserted in a coherent space-and-time context.

The tonsil activation is also the centre of the classical conditioning mechanisms based on the learning of an association with a threatening and unconditioned stimulus (LeDoux, 1986). In compliance with this observation, a study shows that people suffering from PTSD develop responses conditioned to aversive stimuli quicker than other people. Moreover, the extinction of these conditioned responses is more difficult (Orr and al., 2000).

Finally, as specified in Figure 4, it is interesting to point out that the superior cortical structures can have an inhibiting effect on the tonsil, contributing to reducing the response of fear. Thus, even though the memories encoded by the tonsil are more resistant to change, they can be inhibited by the high level cortical structures involved in the verbal recoding of a traumatism. In other words, we have the means to control and/or regulate, at least partially, the stressing consequences of our traumatic memories. This regulation goes through the integration of a memory within an autobiographical context. This integration allows the cognitive re-evaluation of the meaning of the traumatism and some retrospect towards the past experience.

In short, the memories of a traumatism can be of two types: "flashbacks" and the ordinary autobiographical memories. A number of arguments from cognitive science suggest that both the types of memories are sustained by two independent memory systems that function in parallel. In compliance with the double representation of the memory of a traumatism of Brewin and his collaborators, both systems are subject to disturbances of opposite direction during a highly activating situation, like a traumatic event. This theory of dual representation in memory is not only a good description of the collected scientific evidence, it also leads to interesting clinical implications like those evoked by Brewin (2001). For the author, the constitution of a verbal autobiographical memory integrated in time and space inhibits the activation of flashbacks, at least for the integrated situational information in the verbal representation. This verbal recoding can be done through the confronting with the painful points of the traumatic memory (the *"hot spots"*). Of course, the process must be repeated several times, because the information contained in the SAM that has to be recoded in the VAM can be of important volume. Figures 5 and 6 resume the two stages of the recoding mechanisms of the characteristics of the trauma.

As illustrated in Figure 5, the response of fear produced by the tonsil stays activated as long as all the traumatic indications have not been recoded by the VAM (partial coding of the F1-F10 indications only). The repetition of this process of coding of the traumatism, for example by an exposition to imagery of the traumatic memory enables one to recode the traumatic indications (from F1-F20) and progressively inhibit the response of fear (Figure 6). Since the capacity to recode of the VAM is limited, the efficiency of the process often depends on its multiple repetitions.

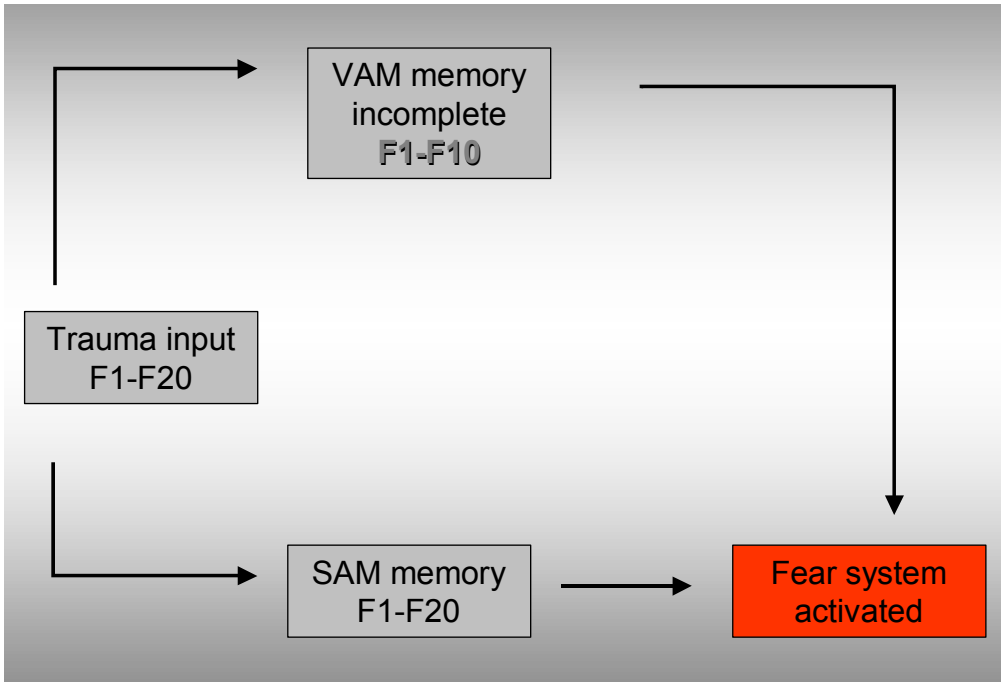


Figure 5: Few trauma cues (re)coded in the VAM → Fear response activated.

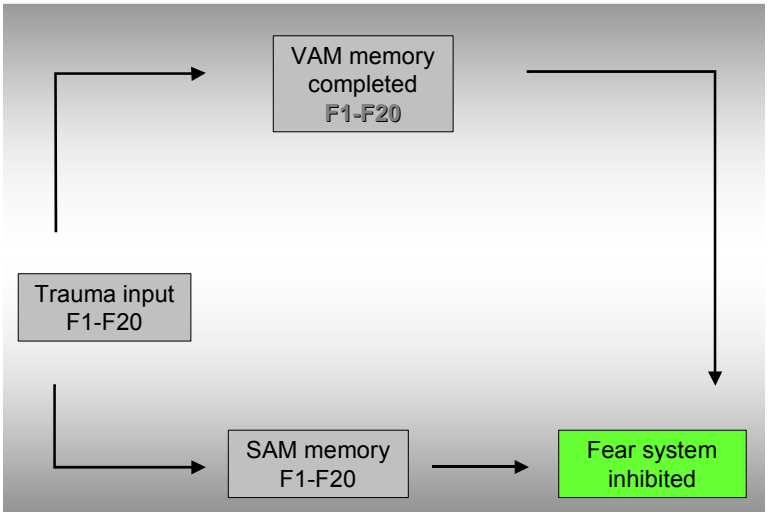


Figure 6 : All the traumatic indications (re)coded to the VAM → response of fear inhibited.

From a descriptive point of view, the memory of people suffering from PTSD characterizes itself by intrusive memories produces by the SAM. These memories appear quickly and spontaneously, intruding in mind at a high frequency. They manifest themselves easily in the form of images or perceptive sensations. Thus, they are commonly known under the generic term “intrusive images”. These images are accompanied by a high physiological awakening and are experienced like reproductions of the trauma (flashbacks). Other memories of the trauma of the same nature can also be more fragmented and consist of tactile, visual, auditory and/or olfactory sensations. The latter memories can have the quality of flashbacks without necessarily correspond to an easily recognisable event. Rothschild (2000) calls these memories “bodily memories” underlining their perceptive nature. All these “intrusive memories” distinguish themselves qualitatively from the “ordinary memories” of the traumatic event (auto-biographical memories). Thus, the “ordinary auto-biographical memories” are retrieved in long-term memory by an intentional research. On the contrary, the “intrusive memories” appear in the field of awareness in an automatic way and completely independently from the will of the person. Very often, the individual claims not having wished to relive these intrusive images and, on the contrary, had tried to suppress them in vain. In the flashbacks, the emotion seems to be synthesized in its original intensity. Often, the evocation of the traumatism is enough to activate the intrusive images. However, with time, the individuals become capable to deliberately recall and describe certain aspects of their traumatic experience in an unemotional way, without provoking complete flashbacks. However, the flashbacks can still be aroused by the recalling of certain details of the traumatism or by the unexpected indications of recovery. It is interesting to consider that any object or sensation can constitute an indication of recovery of an intrusive image conserved by the SAM. Very often, these indications of recovery maintain no explicit link with the original traumatism. The understanding of these implicit links has long stayed in the shadow. Recently, a series of experimental studies shows us the link existing between the idiosyncratic stimuli and the original traumatism is often one of space-and-time (Michael and Ehlers, 2007). In other words, any perception or sensation (even the most insignificant) having appeared at the same time (or just before!) the trauma can, successively, constitute an indication of recovery of an intrusive image. For example, a man imprisoned for years by terrorists presented important reactions of panic every time someone knocked at the door. During the treatment and with a meticulous personal observation, he progressively was able to link this anxious situation with his imprisonment. Indeed, his captors always knocked on the door before they would enter to interrogate him. As predicted by the VAM-SAM model, the progressive understanding of the nature of the link has progressively enabled him to inhibit the activation of the response of panic that was previously associated to it and the constitution of a verbal narration of the event. In other words, the intrusive traumatic memory is recorded within the ordinary autobiographical memory.

3.3.3. Control strategies of threat and symptoms

In a general way, PTSD characterizes itself by an alternation between reliving and avoiding the memories of the trauma. Indeed, the individuals suffering from PTSD try to spontaneously face their suffering by a number of cognitive control strategies (thought suppression, dissociation, etc.) and behavioural strategies (preventive conduct, alcohol/medication, abandon of activities, etc.). It is presently accepted that these control strategies enable the people suffering from PTSD to avoid the confrontation with their upsetting memories and emotions, their thoughts, and the people, the places, the situations related to the original trauma. Yet, if these control strategies diminish the emotional activation on the short term, they however imply a series of undesirable paradoxal consequences on the long term. This intuitive observation relies presently on solid empirical data. Thus, for example, Wegner (1994) has shown that thought suppression directly participates to the augmentation of the frequency of appearing images that were originally suppressed. A simple example lets us illustrate the phenomenon known us “the white bear effect”. If we ask a person, left alone during 5 minutes, to report the contents of their thoughts during that time, it is highly improbable that they will have thought of “a white bear”. Now, if we specifically ask the person not to think of a white bear, the frequency of thoughts concerning the white bear will augment depending on the condition set earlier. We today consider the ironic effects of this nature to be the foundations of the augmentation of the frequency of intrusive images in the frame of PTSD.

For Ehlers and Clark (2000), the control strategies contribute in various ways to the creation of a sense of “present threat”. Firstly, they directly produce symptoms of PTSD by ironic effects like those described by Wegner (1994). Secondly, they prevent the change of the negative cognitive evaluations because they contribute to blocking the provision of new information able to invalidate them. Finally, they divert the recoding of the memory of the traumatism from the SAM to the VAM, because the process needs a certain degree of exposure to the traumatic representations.

3.3.4 Conclusion and clinical implications

As illustrated in Figure 2, for Ehlers and Clark (2000) the people suffering from PTSD carry out a cognitive treatment particularly of the information on the traumatic event and/or its consequences. This treatment participates in the constitution of a subjective feeling of “present threat” through three dysfunctional cognitive processes: (1) memory processes highly dominated by the perceptive memories of the traumatic event, reported in memory involuntarily and through indications of recovery, weakly integrated with other autobiographical memories of the person; (2) the cognitive appraisal of the trauma and/or its consequences, notably the negative ones; and (3) the control processes of the mind leading to ironic effects on the treatment of traumatic information (i.e., thought suppression avoidance behaviours, dissociation, etc.). All these processes will have different consequences:

i. The traumatic information is subject to a chronic treatment. The people suffering from PTSD are often incapable of prevent the stimuli related to the traumatism (indications of recovery) from automatically activating the emotionally charged traumatic memories (intrusive images, flashbacks, etc.). Consequently, these individuals have a hard time considering the trauma as a past event limited in time.

ii. The treatment of the traumatic information is prematurely inhibited. The individuals suffering from PTSD tend to consolidate in autobiographical memory only the partial and deformed memory of the traumatism. Moreover, the memory will not be reassessed by the negative cognitive evaluations that confirm it and the control strategies that reduce the chances of reassessing it.

iii. The appraisal of the trauma and/or of its consequences is catastrophic. The person is incapable of considering the traumatism as an isolated event, limited in time. Moreover, the negative evaluations associate themselves with negative emotions of a high intensity (depending on the type of negative evaluation of fear, anger, guilt, shame, sadness) that tend to confirm the catastrophic character of the situation.

From these observations, the general principle of the intervention in the case of PTSD will be to help the person to reduce his/her subjective sense of “present threat” to help him/her reconstruct a sense of security and trust. In the case of classical cognitive-behavioural therapies, this therapeutic work will exercise itself on three axes of intervention: (1) the exposure to revivifying the traumatism (exposure in vivo or more often to imagery), (2) the cognitive restructuring of the dysfunctional evaluations, and (3) the learning of acceptance strategies instead of emotional control strategies.

During the exposure to revivifying, we ask the person to evoke the trauma in all its sensorial details. The person starts his/her tale as if he/she was reliving the trauma, by starting with the most painful images from the event (hot spots), and by reporting the facts in detail in the first person of the present tense. The traumatic memory is elaborated and integrated in context of the previous and following autobiographic experiences of the traumatism through a recoding of the “hot spots” into consciously accessible memories.

From this process, traumatic information will acquire a context (including the localisation in the past), which will eliminate the sense of “present threat” and restore the sense of security. The repeated recovery of the information related to the traumatism within the autobiographical memory system will enable to integrate this information within the pre-existing autobiographical knowledge of the person. The traumatism will be assimilated producing at the same time the changes in the evaluations, and eventually in the idea of itself and of the world. This process is accompanied by a cognitive restructuring.

However, it is possible to complete the modification of the dysfunctional evaluations through a Socratic questioning. Finally, the therapeutic approach must limit the spontaneous use of behavioural strategies and cognitive control strategies that prevent the creation of the memory, exacerbating the symptoms, and preventing the re-examination of the problematic evaluations.

These principles are contained in various interventions protocols of cognitive-behavioural inspiration especially in the techniques of exposure associated (or not) to the cognitive reappraisal programmes. The therapeutic efficiency of these intervention methods, and especially the exposure to reliving scenes, is presently well established by meta-analyses and by the National Institute for Health and Clinical Excellence (NICE, 2005).

Recently, a number of authors have asked themselves if the exposure to reliving trauma could be considered the optimal procedure to activate traumatic memories and to achieve a cognitive reappraisal of the dysfunctional evaluations. This question revealed itself following the observation that relieving reduces the emotions of fear, but leaves the other emotions (anger, shame, etc.) interchanged. (Grunert and al. 2007). Thus, a new technique of imagery is beginning to surface through the Anglophone community: the *imagery rescripting (IR).* The IR can be applied alone or in association with another procedure, like the exposure to revivifying scenes. The basic principle of this procedure is to integrate new structuring information within the revivifying of the traumatism. Very often, we ask the person, during the imagery of the traumatism, to focus on his/her emotions, his/her motivations and his/her needs. When the person succeeds in expressing these points, he/she is invited to re-inject this information in a new image of the trauma. This will often lead the person to not only express his/her emotions and his/her inhibited needs, but also to adopt another point of view on the traumatic event. Moreover, we can consider that this method also exceeds the cognitive reappraisal, because it calls on a modality of procedural treatment apparently better suited to reach the implicit memories in PTSD.

In the field of PTSD, there presently exist various variants of this procedure. The most common aim for the rescripting of the traumatic memory through imageries of control (i.e., end in imagery a point of the traumatism that has been until then suspended; visualise the experienced trauma during the childhood through the eyes of an adult; imagine the accident in the presence of a guardian angel (Arntz and al. 2007) or of compassion (see oneself with compassionate eyes; imagine that we are acting at the best of our possibilities at that precise moment; imagine that we let the deceased person go; Gilbert and al., 2004).

A recent study compares the efficiency of therapeutic exposition with IR to that of exposure alone (Arntz and al. 2007). The study shows over 67 individuals suffering from PTSD that both conditions are equally efficient in reducing the gravity of the general PTSD symptoms. However, the IR complement reveals itself better on three points. Firstly, the condition with IR enables the reducing of the percentage of “drop out”. Secondly, it allows improving the management of emotions of anger, hostility and guilt. Finally, it tends to reduce the sense of helplessness of the therapists and to increase its degree of satisfaction.

In résumé, this study suggests that the adding of the IR contributes to rendering the PTSD treatment more efficient at least for the emotions other than fear (anger, guilt, etc.) and for the people resistant to more conventional treatments (i.g, those who present a clinical tableur aimed primarily at anger). This last point has been confirmed by Grunert and al. (2007) who have observed the disappearing of symptoms following an IR intervention on 19 out of 23 PTSD patients having not benefited of a previous conventional treatment. Moreover, the IR tends to render the treatment more acceptable for the patient (reducing drop out) and for the therapist alike (increasing their satisfaction and reducing their helplessness). Knowing the difficulty associated with the treatment of PTSD, for the patients as well as for the therapists, these advantages cannot be neglected.

References

APA (1980). *Diagnostic and Statistical Manual of Mental Disorders* (3rd edition). Washington, DC: American Psychiatric Association.

Arntz, A., Tiesema, M., & Kindt, M. (2007). Treatment of PTSD: A comparison of imaginal exposure with and without imagery rescripting. *Journal of Behavior Therapy and Experimental Psychiatry*, 38, 345-370.

Brewin, C. R. (2001). A cognitive neuroscience account of posttraumatic stress disorder and its treatment. *Behaviour Research and Therapy, 39*, 373-393.

Brewin, C. R. (2003). *Post-traumatic stress disorder : Malady or myth ?* London, UK: Yale University Press.

Brewin, C. R., (2006). Understanding cognitive behaviour therapy: A retrieval competition account. *Behaviour Research and Therapy, 44*, 765-784.

Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation of posttraumatic stress disorder. *Psychological Review, 103*, 670-686.

Bryant, R. A., & Guthrie, R. M., (2005). Maladaptive appraisal as a risk factor for posttraumatic stress: A study of Trainee firefighters. *Psychological Science, 16*(10), 749-752.

Ceschi, G, & Van der Linden, M. (2008). L'état de stress post-traumatique: une perspective cognitive. In Van der Linden, M., & G. Ceschi (Eds.), *Traité de psychopathologie cognitive : Etats psychopathologiques* (Tome 2, pp 55-107). Marseille : Editions Solal.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*, 319-345.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*, 20-35.

Gilbert, P. and C. Irons (2004). A pilot exploration of the use of compassionate images in a group of self-critical people." *Memory 12*(4), 507-516

Grunert, B. K., Weis, J. M., Smucker, M. R., & Christianson, H. F. (2007). Imagery rescripting and reprocessing therapy after failed prolonged exposure for post-traumatic stress disorder following industrial injury. *Jouranl of Behavior Therapy and Experimental Psychiatry, 38*, 317-328.

Holmes, E. A., Brewin, C. R., & Hennessy, R. G. (2004). Trauma films, information processing, and intrusive memory development. *Journal of Experimental Psychology: General, 133*, 3-22.

LeDoux, J. E. (1986). Sensory systems and emotion: A model of affective processing. *Integrative Psychiatry, 4*, 237-248.

Michael, T., & Ehlers, A. (2007). Enhanced perceptual priming for neutral stimuli occuring in a traumatic context : Two experimental investigations. *Behaviour Research and Therapy, 45*, 341-358.

Nadel, L., & Jacobs, W. J. (1998). Traumatic memory is special. *Current Directions in Psychological Science, 7*(5), 154-157.

NICE (2005). *Clinical Guideline for the management of PTSD in adults and children in primary and secondary care. Summary of recommendations for health professionals* (www.nice.org.uk/cg026quickguide).

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, NY: Norton & co.

Schnyder, U., Moergeli, H., Klaghofer, R., & Buddeberg, C. (2001). Incidence and prediction of posttraumatic stress disorder symptoms in severely injured accident victims. *American Journal of Psychiatry, 158*, 594-599.

Tulving, E., & Schacter, D. L. (1990). Priming and human memory systems. *Science, 247*, 301-306.

Wegner, D. M. (1994). Ironic processes of mental control. *Psychological Review, 101*, 34-52.

Wells, A. (1997). *Cognitive therapy of anxiety disorders: A practice manual and conceptual guide*. Chichester, GB, Wiley.

Wells, A. and S. Sembi (2004). Metacognitive therapy for PTSD: A core treatment manual. *Manuscript submitted to publication*.

3.4. Diagnoses

Anyone exposed to a traumatic event may react severely in ways that may have long-term effects on them. The stressor may be either an overwhelming traumatic experience involving serious threat to the security or physical integrity of the person or to others, or an unusually sudden significant or threatening life change. It can be caused by a man-made or natural catastrophe and could be micro- (involving a small number of persons) or macro-social (involving a large number of persons).

Indeed a catastrophe can be natural, like an earthquake, a volcanic eruption, a cyclone, a snowstorm, a flood, a fire etc. or the result of human behaviour such as war, genocide, mass deportation, terrorist acts, or plane, boat or train accidents, or even, at a smaller case, a hostage situation, an armed attack, domestic violence, aggression, rape, conjugal rape, suicide or an accident for example.

As Dr Herman places the many symptoms of PTSD into three different categories (hyperarousal, intrusion and constriction), we can assume that these very different critical incidents have in common the fact that, after an initial state of « daze », they most generally produce:

- **confusion:** caused by an unexpected event which disturbs the daily routine creating a lack of understanding, constriction of consciousness and narrowing of attention;
- **emotional overwhelming**: produced by confrontation with an event that involves death or serious injury, or threat of physical injury;
- **powerlessness or helplessness**: the individual is no longer in control of his own life, but becomes the object of malicious individuals, the elements or fate.

Although each individual's reaction may occur in other disorders, the stressful event or the continuing unpleasantness of circumstances is the primary and overriding causal factor, and the reactions would not have occurred without its occurrence. Indeed, it is said (ICD-10) that predisposing factors such as personality traits or previous history of mental disorders may precipitate the appearance of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. In other words, the notion of premorbidity is not considered as appropriate in this case, the reaction being a direct consequence of the critical incident.

These responses as a whole constitute: “**acute stress disorder**” (DSM-IV) or “**acute stress reaction**” (ICD-10).

Often, these reactions progressively diminish as the individual recognises and accepts his own emotions. The responses vary greatly according to the person as well as the type and intensity of the event. If the emotional reactions are left to continue, “**Post-traumatic stress disorder**” or “**Adjustment disorder**” may develop.

Tab 1 (**annexe**) provides a comparison between Acute Stress Disorder (ASD) and Post-traumatic Stress Disorder (PTSD) from the DSM-IV. The diagnoses have the following in common:

- the exposure to a traumatic event

- the reexperiencing of the event

- the avoidance of associated stimuli

- the symptoms of anxiety and

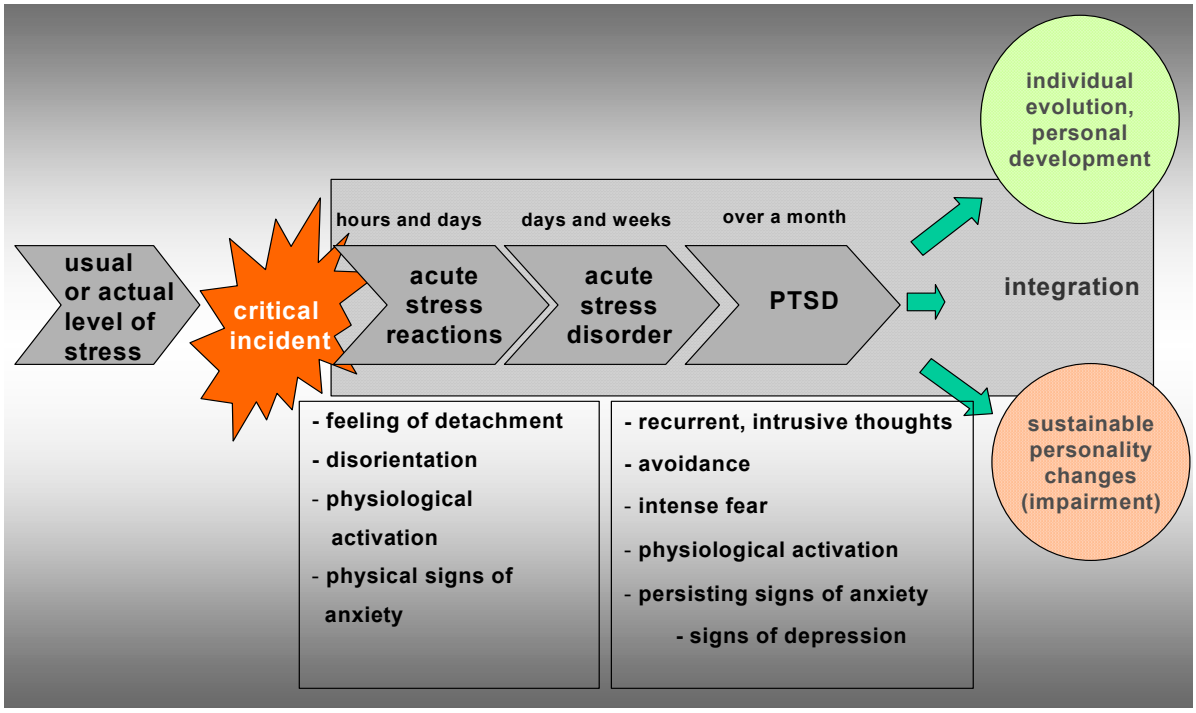
- the social and occupational impairment.

The diagnoses differ with regard to the timeframe: ASD lasts between two days and four weeks and can occur within four weeks, while Acute PTSD is limited to three months, and Chronic PTSD is unlimited. The only difference concerning the symptoms is the presence of dissociative symptoms (numbing, detachment, reduction in awareness of the surroundings, derealisation, depersonalisation and dissociative amnesia) in ASD. However, we find in criteria C. of PTSD some of these symptoms (inability to recall an important aspect of the trauma, diminished interest or participation in significant activities, feeling of detachment or estrangement from others, restricted range of affect), which makes these diagnoses rather similar.

Yet, a more careful observation might allow us to realise that ASD appears to emphasise the state of shock and the anxiety produced by the proximity of the event's onset, while PTSD seems to describe the following stage of the very same process, the stage where signs of depression show (diminished interest, detachment, restricted range of affect, inability to have feelings of affection, sense of a foreshortened future, loss of expectation).

Tab 2 (**annexe**) compares Acute Stress Reaction (ASR) to PTSD in the ICD-10. The immediate connection of ASR with the event and the psychic shock appear here even more clearly, while PTSD is described as a delayed and protracted response. ASR reveals a dazed state, constriction of the field of consciousness, narrowing of attention, disorientation and confusion. On the other hand, reliving the trauma and avoidance mechanisms appear only in PTSD.

For this reason, we should recommend the use of the ICD-10 diagnosis where the difference is more marked and accurate. Concerning the **Tab 3 (6.4)**, comparing the RAF to the ICD-10 to the ESA of the DSM-IV, the latter suggesting the analysis of the following correspondence: "*the diagnostic criterion for the research of ICD-10 of an acute reaction to a different stress factor than those of the DSM-IV in several ways: 1) first of all, the anxious symptoms are included; 2) the beginning of the symptoms must occur in the hour following the stress factor and 3) the symptoms must start to reduce in the following eight hours for the transitory stress factors and in the following 48 hours for the prolonged stress factors. Contrary to DSM-IV, the diagnostic criterion for the research of ICD-10 do not necessitate that the dissociative symptoms be present or that the event be relived in a persistent manner".* For the comparison between the diagnostic of PTSD in the two manuals (cf. **Tab 4 / 6.5)**, the DSM notes that: *"the diagnostic criterion for the research of the ICD-10 of a state of post-traumatic stress provide a different criterion for the stress factor: a situation or an "exceptionally threatening or catastrophic event that would lead to evident symptoms of distress to most of the individuals involved". The diagnostic algorithm of the ICD-10 differs from that of the DSM-IV in that the criterion D of DSM-IV constituted by the symptoms of activation is not compulsory but can be replaced by the incapacity to recall important aspects of the traumatism. On the opposite of DSM-IV, the diagnostic criterions for the research of ICD-10 do not specify a minimum period of time for the symptoms".* Moreover, the clinical experience shows that the dissociative disorders (described only in the state of acute stress) aren't rare in people suffering from PTSD.



As expressed earlier, if an exceptionally stressful life event produces an acute stress reaction, a significant life change leading to continued unpleasant circumstances causes an Adjustment Disorder. You will find here below the description given by the ICD-10.

Acute stress reactions ICD-10	Acute stress disorder DSM-IV
Severe transitory disorder occurring immediately after the factor of exceptional physical or psychological stress and usually disappearing in a few hours or days.	Development of a characteristic and dissociative anxiety as well as other symptoms that occur in the months following the exposure. Its length goes from 2 days to 4 weeks.

Post-Traumatic stress disorder DSM-IV / ICD-10

Development of characteristic symptoms following the exposure to a factor of stress.

Acute: less than 3 months

Chronic: three months or more

With differed occurrence: the symptoms start after 6 months

Dissociative disorders:

We would use this term to qualify a state of post-traumatic stress of which the reactions would be specifically dissociative (dissociative amnesia, dissociative stupor, and dissociative disorders of the motivity and the organs of the senses.

Adjustment disorders:

State of stress and emotional disturbance, impeding on the professional and social functioning, occurring on a certain period of adaptation to an important existential change. (described next page).

Chronical personality modification after experiencing a catastrophe (ICD-10)

A durable modification of the personality following the exposure to a factor of catastrophic stress. The factor of stress must be of a certain intensity so that it is not necessary to invoke the personal vulnerability to show the impact on personality.

These effects can concern: the victims of the situation, the witnesses to the event, the rescuers and the intervening people, or the close circle to these three categories.

F43.2 Adjustment disorders

States of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life- change or to the consequences of a stressful life-event (including the presence or possibility of serious physical illness). The stressor may have affected the integrity of an individual's social network (through bereavement or separation experiences) or the wider system of social support and values (migration or refugee status). The stressor may involve only the individual or also his or her group or community.

Individual predisposition or vulnerability plays a greater role in the risk of occurrence and the shaping of the manifestations of adjustment disorders than it does in the other diagnose studied here, but it is nevertheless assumed that the condition would not have arisen without the stressor. The manifestations vary, and include depressive mood, anxiety, worry (or mixture of these), a feeling of inability to cope, plan ahead, or continue in the present situation, and some degree of disability in the performance of a daily routine. The individual may feel liable to dramatic behaviour or outbursts of violence, but these rarely occur. However, conduct disorders (e.g. aggressive and dissocial behaviour) may be an associated feature, particularly in adolescents. None of the symptoms are of sufficient severity or prominence in their own right to justify a more specific diagnosis. In children, regressive phenomena such as a return to bed-wetting, baby speech, or thumb-sucking are frequently part of the symptoms pattern. If these features predominate, F43.23 should be used.

The onset is usually within 1 month of the occurrence of the stressing event or life change, and the duration of symptoms does not usually exceed 6 months, except in the case of prolonged depressive reactions (F43.21). If the symptoms persist beyond this period, the diagnosis should be changed according to the clinical picture present, and any continuing stress can be coded by means of one of the Z codes in Chapter XXI of ICD-10.

Contacts with medical and psychiatric services because of normal bereavement reactions, appropriate to the culture of the individual concerned and not usually exceeding 6 months in duration, should not be recorded by means of the codes in this book but by a code such as disappearance or death of family member, plus for example counselling, or stress not elsewhere classified. Grief reactions of any duration, considered to be abnormal because of their form or content, should be coded as Prolonged depressive reaction (F43.21), Mixed anxiety and depressive reaction (F43.22), With predominant disturbance of other emotions (F43.23), With predominant disturbance of conduct (F43.24) or With mixed disturbance of emotions and conduct (F43.25). Those that are still intense and last longer than 6 months should be coded Prolonged depressive reaction (F43.21).

Diagnostic guidelines: diagnosis depends on a careful evaluation of the relationship between: a) form, content, and severity of symptoms; b) previous history and personality; and c) stressful event, situation, or life crisis. The presence of this third factor should be clearly established and there should be strong, though perhaps presumptive, evidence that this disorder would not have arisen without it.

Includes: *culture shock, grief reaction, hospitalism in children.*

Exclude: *anxiety of separation in childhood (F93.0)*

The definition of these diagnostic categories does not exclusively rely on the symptomatology and evolution but also on one or the other of the following etiological factors:

► a particularly stressing event leading to an acute reaction to a stress factor

► a particularly memorable change in the life of the subject

3.5. Types of reactions

re-experiencing the trauma

(recurrent images, thoughts, perceptions, nightmares, illusions, hallucinations, a sense of reliving the experience, or flashback episodes);

In children, repetitive anxious games, which may be monotonous or which may repeat the event, and frightening dreams without recognisable content, may occur;

avoidance

intense psychological distress and/or physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event;

voluntary efforts are made to avoid thinking about the event (associated feelings, conversations, inability to recall aspects of the trauma) or anything connected with it (places, people, situations);

concentration and memory deficits, narrowing of attention, partial or global amnesia;

feelings of detachment or estrangement from others,

reduction of attention to others, difficulty in concentrating, diminished interest or participation in significant activities;

signs of anxiety, irritability

or outbursts of anger, agitation, hyperactivity, difficulty falling or staying asleep, a perpetual state of alertness, exaggerated startle response. Autonomic signs of panic (tachycardia, sweating, hot flushes) are commonly present.

In children, abnormal agitation, fretfulness, irritability, desire to be alone, strong reactions to separations, fear of going alone to the toilet at night, fear of darkness and regressive behaviour, may occur;

signs of depression

such as: feelings of guilt, lack of self-esteem, feeling “dirtied or sullied”, a sense of foreshortened future, loss of expectation, hopelessness. Suicidal ideation or acts of self-harm are not infrequent;

feeling misunderstood and/or unappreciated;

psychosomatic disorders:

physical exhaustion, weakness of the immune system, headaches, back and muscular pains;

the person tends to isolate himself,

no longer participates in his usual social activities and experiences difficulties at work as well as in domestic affairs. The disturbance may create significant distress or impairment in the individual’s ability to pursue some necessary task, such as obtaining necessary assistance or mobilising personal resources.

For the same purpose, a child might show reduced interest in his school activities, or, on the contrary, sudden excessive interest;

excessive use of alcohol or drugs may be a complicating factor;

tendency to report previous traumatic experiences

or even to link the actual critical event with previous distressing situations. The person has the impression that his/her whole life consists of nothing but critical events and tends to act in a manner that often leads to further victimisation.

3.6. Categories of reactions

As previously noted, anyone exposed to a traumatic event may produce strong reactions. Although the responses vary greatly according to the person as well as the type and intensity of the event, we can organise these various reactions into four major categories. These distinctions are indeed theoretical, as it is practically impossible to separate the mind from the body or its emotions. Confronted with danger, the organism reacts in such a way as to ensure its survival. Whichever kind of defensive mode is chosen, the physiological reactions remain the same, independent of the type of stressor, and whether the danger is actual or threatened.

Physiological reactions	**Cognitive or intellectual reactions**
- lack of energy, physical exhaustion; - weakness of the immune system (tendency to catch colds, flu, etc.); - endocrinal disorders (menstrual, thyroidal disorders, etc.); - headaches, back and muscular pain; - cardiovascular disorders; - shivering and hot flushes; - changes in sexual habits (an increase or a decrease in libido, absence of orgasm...); - other somatic disorders.	- memory disorders, inability to recall an important aspect of the trauma; - difficulty concentrating, narrowing of attention; - constriction of consciousness; - recurrent and intrusive thoughts; - lack of self-esteem, lack of confidence in judgement and decision-making; - lack of objectivity; confusion; - state of shock.
Psycho-emotional reactions	**Behavioural reactions**
- surprise, disbelief and consternation; - feeling of detachment, restricted range of affect; - fears and phobias; - vulnerability, feelings of guilt and shame, feeling « dirtied or sullied »; - powerlessness, helplessness; - mood disorders: anger, anxiety, sadness, solitude, depression and hopelessness; - feeling misunderstood, unappreciated; - tendency to extend from an occasional state of victim to a more permanent identity.	- diminished participation in significant activities, impairment in social and occupational areas; - impairment in ability to obtain necessary assistance or to mobilise personal resources; - irritability, hostility, instability, maniacal behaviour; - sleeping and eating disorders; - tendency to addiction (alcohol, drugs or medicine).

ACUTE AND CHRONICAL PSYCHOTRAUMATIC SYNDROMES

event	clinic	diagnostic DSM-IV	diagnostic ICD-10
immediate reactions from a few minutes to one day	**dissociation** **physiological activation** **cognitive evaluation**		**Acute stress reaction** (F43,0)
post-immediate reactions from 2 days to 1 month	**dissociation** **recurrent thoughts** **avoidance** **physiological activation** **cognitive evaluation**	**Acute stress disorder** (308.3) **PTSD "acute"** (309.81) (*less than 1 month*)	**Transitory PTSD** (F43.1) (*less than 1 month*)
sustainable distress over 1 month © michel berclaz 2003	**recurrent and intrusive thoughts** **avoidance** **physiological activation**	**PTSD "acute"** (309.81) *1 to 3 months* **PTSD «chronic»** (309.81) (*over 3 months*) **PTSD with Delayed Onset** **Chronic Adjustment disorder** (309.xx)	**Sustainable PTSD** (F43.1) *from 1 month to 2 years* **Enduring personality change after catastrophic experience** (F. 62.0) (*over 2 years*)

Grazia Ceschi notes that, based upon a number of recent studies, the presence of the reactions marked by a (*) predict in a significant way the occurring of a durable reaction of stress. However, we must admit that these reactions are peculiar to each of these stages and that the occurring of immediate reactions does not subsequently imply post-immediate reactions. Moreover, PTSD can be differed, which means that the symptoms appear in a delayed way even if the person has not presented a state of acute stress, not even in an immediate reaction. When we say "cognitive evaluation", we mean appraisal, an alarmist evaluation (often mostly subjective) of the event where the person disqualifies herself, feels overly guilty, considers the event as a the source for a dramatic and durable modification of herself and her context, where she apprehends the future in a very pessimistic way.

As mentioned earlier one of the criticisms emanating from French psychiatrists concerning the diagnosis rests on the fact that PTSD cannot claim to include all the many psychiatric and psychological reactions following a psychological trauma. We share this opinion as we believe that no generalisation such as a diagnosis can describe all the specificities of each individual suffering. Moreover one can be sure that, even from a global standpoint, extraordinary and once in a time events occurring in a short time will produce significally different reactions to repeated events over a long period of time (such as abuse or domestic violence). Despite the fact that these situations are nowadays clearly recognised, their effects are still not yet listed in a independent nosography …hence, that was exactly the aim of PTSD diagnosis.

4. FROM PREMORBIDITY TO RESILENCE

4.1. Concept of premorbidity

The careful study of the diagnoses (see annexe) connected with psychological trauma leads us to the development of some reflections on several notions: the accuracy of premorbidity in this field, as well as the necessity and forms of intervention.

A relatively spread belief through the public as well as within mental health professional circles, as we have seen above, associates the appearing and the strength of the reactions following a critical situation to the intrinsic vulnerability of the individual, even to psychological disorder or a personality disorder present before the event itself. Let's see what ICD-10 tells us on the subject:

Accuracy of the notion of premorbidity in the field of psychological trauma.

Let us start by relating here the elements expressed in ICD-10 concerning this notion:

« Less severe psycho-social stress (« life events ») may precipitate the onset or contribute to the presentation of a very wide range of disorders classified elsewhere in this work, but the etiological importance of such stress is not always clear and in each case will be found to depend on individual, often idiosyncratic, vulnerability. In other words, the stress is neither necessary nor sufficient to explain the occurrence and form of the disorder. In contrast, the disorders brought together in this category are thought to arise always as a direct consequence of the acute severe stress or continued trauma. The stressful event or the continuing unpleasantness of circumstances is the primary and overriding causal factor, and the disorder would not have occurred without its impact...

Although each individual symptom of which both the acute stress reaction and the adjustment disorder are composed may occur in other disorders, there are some special features in the way the symptoms are manifest that justify the inclusion of these states as a clinical entity.

F43.0 Acute stress reaction:

A transient disorder of significant severity which develops in an individual without any other apparent mental disorder in response to exceptional physical and/or mental stress ...

This diagnosis should not be used to cover sudden exacerbation of symptoms in individuals already showing symptoms that ... the criteria of any other psychiatric disorder, except for the personality disorders. However, a history of previous psychiatric disorder does not invalidate the use of this diagnosis.

F43.1 Post-traumatic stress disorder.

Predisposing factors such as personality traits or previous history of neurotic illness may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence.

F43.2 Adjustment disorders

Individual predisposition or vulnerability plays a greater role in the risk of occurrence and the shaping of the manifestations of adjustment disorders than it does in the other diagnose studied here, but it is nevertheless assumed that the condition would not have arisen without the stressor...

The presence of this third factor (stressful event, situation, or life crisis) should be clearly established and there should be strong, though perhaps presumptive, evidence that this disorder would not have arisen without it... ».

Thus, the disorders brought together in this category are not considered as a mental illness, but more as a sort of « normal » reaction after an exceptionally distressing event (as it is now commonly said). Moreover, they are supposed to diminish progressively, as time passes, insofar as the event is integrated in the individual's History, which would actually depend on his or her coping capacities and social support.

We should also admit that « a history of previous psychiatric disorder does not invalidate the use of this diagnosis ». In other words, anybody, without exception, may present strong reactions when confronted with an extremely distressing situation, which all in all seems to make sense!

Nevertheless, the subject is important and interesting enough not to be swept away too rashly. In fact, one should try to understand why premorbitity is so often brought up when treating this subject. My guess is that this has to do with two distinct phenomena. The first might consist of the forms of the reaction, which would be connected with personality traits and structure or personality. The second could be the fact that most of the individuals confronted with a traumatic event tend to report previous traumatic experiences or even to link together the actual critical event and previous distressing situations. This last point would be, according to us, related to the functional dynamics of the human (or maybe any) brain, which tends to be based on associations.

4.2. Personality traits and structures

Personality traits may not only lower the threshold for the development of the syndrome or aggravate its course, but they also have quite an impact on the form of the signs and symptoms. In the same way, the personality's structure, when confronted with an extremely stressful event, tends to appear in a far clearer way. In other words, when the individual presents strong reactions, his or her defensive mechanisms and deepest fears will appear quite clearly, revealing his or her personality traits and structure. Thus, psychiatrists and psychologists can easily be misled, brought to think they are confronted with the expression of a neurotic illness. Actually, the responses greatly vary according to the person and his or her vulnerability as well as the type and intensity of the event, but nonetheless, the form and kind of reaction will inevitably be related to the personality structure.

Following the example of Jean Bergeret, let us recall certain elements concerning normality and personality structure. According to the definition, « normal » means what is connected with the norm. The norm being a social phenomenon, normality remains a perfectly relative notion, different from one culture to another and subject to changes throughout time. G. Canguilhem assumed that the "normal" being was the one adapted to its environment, while illness appears with the reduction of the environment's tolerance.

With S. Freud, we tend to consider neurotic individuals (where the personality is organised around the Oedipal complex and under the genital primacy), whether suffering from neurosis or not, as normal, while psychotic structured persons (for whom the Oedipus complex is not a factor of organisation and the genital economy is not essential) as insane. Nevertheless, experience has shown that the transition from neurosis to a certain form of normality is as difficult as the one from psychosis to another form of normality. Nowadays, we tend to differentiate the « normal state » from mental disorder not according to structure or adaptation, but according to an « out-of-balanced state », decompensation or a lack of personality structure. In other words, psychotic, as well as neurotic individuals are considered as « normal » as long as they are well balanced, even though the mental disorder may be presented in both cases.

However, and still according to Bergeret, one must underline the existence of confusion concerning the terms "neurotic" and "psychotic". Indeed, we often use « psychotic symptoms » for delirium and hallucination or « neurotic signs » for hysterical conversion or obsessive rituals, when in fact we can spot delirious episodes in a non-psychotic structure. In addition, phobias are seldom from neurotic aetiology. Moreover, the symptoms should always be considered according to their relative, relational, communicative and economic value.

In the same way, it is not infrequent to encounter a neurotic defence mode (including symptoms) in the protection system of an actual psychotic structure, as well as a psychotic defensive mode in the camouflaging of an Oedipal origin of conflicts within a true neurotic structure.

For these various reasons, and as a precaution in order to avoid the risk of hazardous diagnosis, we tend to use the terms of « mode » or « look » to qualify elements of neurotic or psychotic shape. Moreover, it appears necessary to differentiate the imbalance of a psychotic structure from a psychotic episode in specific cases those involving delivery, trauma or surgical intervention, for example. Indeed, these very situations may produce a modification of the body representation and mobilise strong discharges of drive, irrelevant to a psychotic structural basis. In the same way, an adequate intervention allows a "recompensation" on its own structure, the passage of one structure to another being impossible.

In addition, in the same line as the works of anglo-saxon psychoanalysts and following the work of Mélanie Klein, W Bion brings a light leading to even more complicated notions of personality structures. Indeed, from this idea from which the structuration is made, from a young age, but progressively throughout the psychological development, we all have in some sense access to each of our stages. Moreover, the kleinian theory uses the term “positions” (schizoparanoid or depressive) instead “stages”, underlying the mobility of the system and thus the possibility of going from one to another.

Bion also spoke, for example, of a “psychotic nucleus” of which we are all provided with and with which we are more or less in contact, depending on our organisation, our flexibility on defense mechanisms and on the type of conflicts or situations that we must confront. This approach allows us to explain the fact that, in some situations where the subject’s life or that of others is in danger – which are the situations we take interest in here – the defence mechanisms and anxiety presented are those generally attributed to the psychotic structure (fear of death; denial of all or a part of reality, her as amnesia or avoiding; objectifying; divide; projection for ex.)

However, depending on the relationship with the parents, frustrations, encountered conflicts, trauma and sometimes hereditary factors, as well as defences organised by the ego, the psyche will organise itself in a stable structure (or actually not stable) qualified as neurotic, psychotic or the organisations belonging to borderlines. As long as the individual is not subject to extreme internal or external difficulties, he or she will not be « insane ». When the « crystal » breaks following a critical incident, it will happen according to the basic structure.

4.3. Neurophysiological base of memory

In an article, the (French-speaking) Swiss, child psychiatrist Jean-Claude Métraux, observes that in war situations or cases of torture, trauma persists over a longer period of time. He notes that it is associated with a series of losses as different as that of one’s relatives, a house, material possessions, a village or country, a limb or the use of part of one’s body, a world-vision or a certain purpose to one’s life. Under such circumstances grief cannot be dissociated from traumatic reactions. Hence the usefulness of the notion of **frozen grief.**

The author explains that a “normal” process of grieving begins with what he calls a “shutting out” phase (denial or non-awareness) during which a minimum level of stability is maintained such as required for the inception of mourning and for the confrontation with an environment transformed by losses. In situations where genuine threats persist for a very long time, grief cannot be allowed since it would drain all the energy required for survival, for hiding, escaping or defending oneself.

He further describes this phenomenon by analogy with the physical reactions to stress i.e. a succession of vasoconstriction and vasodilatations:*”…the blood flow is altered : priority is given to the organs that are vital to immediate survival. Stop lights prevent the oxygen-charged red corpuscles from reaching the digestive and urinary tracts in significant quantities. Whereas the motor functions are flooded with extra supplies. It is as if the only alternative was flight or attack. The essence is that no desire to eat or urinate hamper the need to flee or fight. … In the meantime, the psychological development of grief is delayed”.*

He draws a distinction between coping whereby physical survival is ensured when biological life is at stake, and defence mechanisms designed to guarantee psychological survival against real or perceived threats. Trauma victims cannot wrench their memories away from the traumatic events, previous memories are not accessible and the constant repetition of the memory of the critical events keeps them in a state of full alert so that they are prepared to flee or attack at the slightest sign of danger. As long as these threats persist, the frozen grief will act as *“donning a coat of armour allowing neither sun nor rain to filter through, fitted with a helm impermeable to pain and feelings, whose visor is carefully sealed to prevent any words from penetrating”.* Only once all danger has passed, might the mourning process possibly be able to commence ; a time to rediscover a desire for pleasure, for knowledge, for action and for emotional involvement.

Concerning the reporting of previous trauma by survivors

As mentioned above, most individuals confronted with a traumatic event tend to report previous traumatic experiences or even to link together the current critical event and previous distressing situations. Often health professionals tend to interpret this phenomenon as a pathological grief reaction, or as a sign of particular vulnerability. The cognitive sciences propose another explanation. Indeed, in order to orientate ourselves in unusual situations, our brain seems to compare new stimuli with previous perceptions and a new situation with past experiences sharing some connected elements (impressions, feelings). Thus, it is not surprising if, when confronted with a traumatic experience, we link a new trauma with previous ones.

In order to be more specific, one could quote Daniel Goleman "Emotional Intelligence":

"Other research has shown that in the first few milliseconds of our perceiving something we not only unconsciously comprehend what it is, but decide whether we like it or not; the "cognitive unconscious" presents our awareness with not just the identity of what we see, but an opinion about it. Our emotions have a mind of their own, one which can hold views quite independently of our rational mind."

Those unconscious opinions are emotional memories; their storehouse is the amygdala. Research by LeDoux and other neuroscientists now seems to suggest that the hippocampus, which has long been considered the key structure of the limbic system, is more involved in registering and making sense of perceptual patterns than with emotional reactions. The hippocampus's main input is in providing a keen memory of context, vital for emotional meaning; it is the hippocampus that recognises the differing significance of, say, a bear in the zoo versus one in your backyard.

While the hippocampus remembers the dry facts, the amygdala retains the emotional flavour that goes with those facts. If we try to pass a car on a two-lane highway and narrowly miss having a head-on collision, the hippocampus retains the specifics of the incident, like what stretch of road we were on, who was with us, what the other car looked like. But is the amygdala that everafter will send a surge of anxiety through us whenever we try to pass a car in similar circumstances. As LeDoux put it to me, "The hippocampus is crucial in recognising a face as that of your cousin. But it is the amygdala that adds you don't really like her".

The brain uses a simple but cunning method to make emotional memories register with special potency: the very same neurochemical alerting systems that prime the body to react to life-threatening emergencies by fighting or fleeing also stamp the moment in memory with vividness. Under stress (or anxiety, or presumably even the intense excitement of joy) a nerve running from the brain to the adrenal glands atop the kidneys triggers a secretion of the hormones epinephrine and norephinephrine, which surge through the body priming it for an emergency. These hormones activate receptors on the vagus nerve; while the vagus nerve carries messages from the brain to regulate the heart, it also carries signals back into the brain, triggered by epinephrine and norephinephine. The amygdala is the main site in the brain where these signals go; they activate neurons within the amygdala to signal other brain regions to strengthen memory for what is happening.

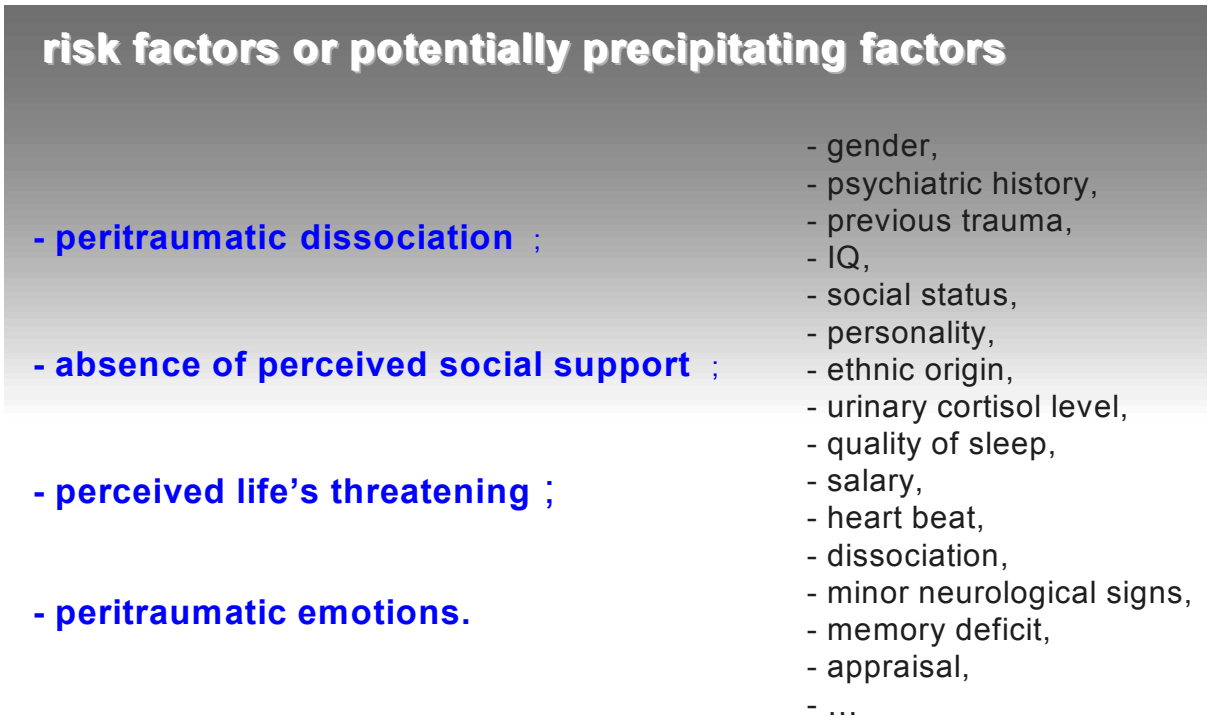
This amygdala arousal seems to imprint in memory most moments of emotional arousal with an added degree of strength – that's why we are more likely, for example, to remember where we went on a first date, or what we were doing when we heard the news that the space shuttle Challenger had exploded. The more intense the amygdala arousal, the stronger the imprint; the experiences that scare or thrill us the most in life are among our most indelible memories. This means that, in effect, the brain has two memory systems, one for ordinary facts and one for emotionally charged ones. A special system for emotional memories makes excellent sense in evolution, of course, ensuring that animals would have particularly vivid memories of what threatens or pleases them. But emotional memories can be faulty guides to the present. One drawback of such neural alarms is that the urgent message the amygdala sends is sometimes, if not often, out-of-date – especially in the fluid social world we humans inhabit. As the repository for emotional memory, the amygdala scans experience, comparing what is happening now with what happened in the past. Its method of comparison is associative: when one key element of a present situation is similar to the past, it can call it a "match" – which is why this circuit is sloppy: it acts before there is full confirmation. It frantically commands that we react to the present in ways that were imprinted long ago, with thoughts, emotions, reactions learned in response to events perhaps only dimly similar, but close enough to alarm amygdala."

Thus, it appears that giving an excessive weight to the connections between the different past situations participates to maintain a certain confusion in the mind of the victim, it is especially likely to be lived as disqualifying for the person, to the eyes of whom the specific experience is unique. This type of disqualification would fatally increase the feeling of not being understood or recognized that the victim experiences. On the other hand, using past experiences to mobilize resources, skills and capacities to confront of the person, can be extremely efficient for the process of recovery.

Moreover, in certain professions like police, customs officers, firemen, urgency or psychiatric nurses (likely to work in contact with violence for ex.) or even teams of international organisations of support, we suggest to use the notion of "cumulative stress". Indeed, if these professionals seem to be less at risk when speaking of Post-traumatic stress disorder, they are however victims of exhaustion, of a certain usury. They are likely to present – in a relatively trivial situation in their experience – intense reactions produced by the effect of the addition of all their past confrontations to potentially traumatising events.

However, Grazia Ceschi notes that a number of epidemiologic studies have progressively extended the list of risk factors, or potentially precipitating factors. Thus, we find an important number of predictive variables. However, two recent meta-analysis – Brewin, Andrews & Valentine (2000 based upon 77 articles) and Ozer, Best, Lipsey & Weiss (2003 based upon 68 articles) – seem to prove that the precocious peri- or post-traumatic variables dispose of a superior predictive power to pre-morbid factors, in order of importance:

For Brewin and colleagues	For Ozer and colleagues
the absence of social support **the level of basic stress** **the gravity of the trauma**	**péri-traumatic dissociation** **the absence of perceived support** **the perceived threat to life** **the peri-traumatic emotions**



In other words, the concept of pre-morbidity as it is, is inappropriate, nor constructive. It would seem evident that ignoring part of the terrain or context would be a form of denial. The above-mentioned researches seem to prove the importance of the history of the person, of the constitution of the personality, of the skills chiselled by experience, of the frailties produced by existence as well as the impact of circumstances and context. Thus, depending on all these various elements, the person will be more or less prepared, more or less vulnerable and more or less protected against certain dramas of existence.

However, we will note that these researches prove that the most pregnant elements seem to be :

- the gravity of the event (threat to life) ;
- the past experiences during of after the situation (dissociation and emotions)
- the subjective feeling of being supported and surrounded from a social point of view.

Concerning this last point, we speak of "subjective feeling" because the reality of the absence or the presence of social support seems much less important than the impression that people can have of it. It comes out that, sometimes, the person – in her distress and her immeasurable suffering – doesn't feel supported, or considers certain positions or actions as an annihilation of support. On the contrary, others will perceive the attitudes or attentions of their close circles as an important and efficient effort of support.

This point is crucial in the legitimating of the immediate and post-immediate intervention, it is essential in the ideology of psycho-social and spiritual support. Indeed, we will take it on in further detail later, no real efficiency has been proved in the various models of intervention. Nothing, for the moment, allows us to claim the preventive aspect of the latter. It seems evident that certain sufferings are durable and resist to all types of help and treatment. In addition, certain specialists think that a precocious intervention presents a high risk of impeding on the natural mechanisms of integration of these dramatic event. What we consider to be "reactions", certain as symptoms, often correspond to the means that the person presents to face the event. For example, the revivifying could be considered a mean of integration of the experience, a way to seize it, a way to find more efficient methods to face such events in the future and finally to fight the feeling of helplessness. The avoiding only protects momentarily the individual of an unbearable confrontation and probably deleterious to any agent that is too stressing. To fight them would mean intervening.

The ideology of psycho-social and spiritual support assumes that surrounding a member of the community in moments of great atrocity is a social duty. The research shows it, feeling supported, accompanied and surrounded has a positive impact on the integration of the event. This support must no impede on the natural defence mechanisms of the individual, but assure him a benevolent presence and help him take contact with his skills as well as mobilizing his resources.

On the other hand, Boris Cyrulnik, (*"Un merveilleux malheur",* Odile Jacob Publishers, Paris) suggests, rather than focusing on the damage, though undeniable, and trying to identify the type of person prone to lasting reactions, that we should concentrate on quite the opposite, on those who recover best, in order to discover the healing processes. Or, in other words, as my grandmother Alice used to say, "to darn a sock you don't start from the hole but from the bits of wool still left". To this end, the concept of **resilience** must be developed.

5. RESILIENCE

Resilience is “the ability to succeed, to live and to develop positively, in a socially acceptable fashion, notwithstanding stresses or adversities which would normally be serious threats with negative consequences” (S. Vanistendael, “Cles pour devenir : la resilience” in “les cahiers du BICE”, Geneva, 1996, p.6). Cyrulnik explains that this ability depends on a number of protective factors such as :

- splitting, when one’s self divides into two parts, one socially acceptable and the other more secluded;
- denial, which allows dangerous realities to be ignored or painful wounds to be glossed over;
- dreaming as a marvellous shelter in which excessively difficult relationships are abandoned;
- intellectualising whereby confrontation, which would entail personal involvement, is avoided;
- abstraction whereby general rules are set out in order to control and avoid the opponent.

However, these protective strategies can often be very costly in terms of development and of psychological balance, whereas other defense mechanisms have been observed both in groups of fulfilled adults and among resilient abused children, such as:

- sublimation, when the driving forces are channelled towards socially valued activities (artistic, intellectual or ethical);
- controlling the emotional investment related to sublimation revealing an ability to withstand frustrations;
- altruism, or devotion to others whereby inner conflicts are avoided and love from others is gained through the happiness one gives;
- humour, which may transform a grievous tragedy into light euphoria. “…since I can make you laugh at my misfortune, I am proving to myself that I am regaining control of my past and that I am not all that much of a victim.” Through humour, suffering is made tolerable;
- creativity which can transform distress into a work of art and a tragic story into the road to social success;
- piecing together one’s sense of identity through the sense of belonging and shaping a narrative identity (through the narration of one’s own story, one’s place in History, one’s values and one’s skills);
- genetic background. Indeed, if this background is flawed by disease, the person will be more prone to become vulnerable. But, quite early on in that person’s development another facet of his/her ability to resist will be shaped by the emotional environment. In fact, most of the elements that are involved in building resilience are determined by:
- the social environment which, by offering chances, opens the way for potential paths towards fulfilment.

In his work, based on broad research, references and clinical situations, Cyrulnik shows how very complex the concepts of trauma and resilience are. He describes the latter as a woven fabric of numerous intertwined factors. Among many other examples, he refers to a comparative study of Jewish children during the Second World War. One group of children was hidden, another deported and a third had fought in the armed resistance. All suffered from depression for a number of years after the war, except for those who had fought in the resistance.

Indeed, those children developed an identity closer to that of the heroes than to the victims. While the group of children who were deported around the age of five registers the highest rate of post-war depressions, it is among the members of this group that the most outstanding social and family successes are noted. In order to overcome the profound wound left by the concentration camps, they over-invested in the happiness of family love and of social success. There were no cases of depression among the resistance fighters, but once they grew up they were satisfied with an average place in society, enough to keep them contented.

The author further states : “In psychology too we reason as mechanics, as if an overall effect can be attributed to single cause. To claim that a stopped up carburettor is causing the car to splutter may lead to the belief that a major traumatism during childhood can explain all suffering later on in life. When an event is too obvious the risk of losing sight of the forest for the trees, is great. In fact, it may well be that an acute, spectacular traumatism is less devastating than a chronic, insidious trauma repeated at a time when the psyche is developing and absorbing its environment”.

Cyrulnik describes a primary sensorial memory, printed onto the neurons enabling certain events to be perceived, and a second memory, made up of recollections, and recorded as private representations. This memory is maintained and constantly brought up to date through the accounts one composes for oneself or for others. In exchange, the view others take of the person and of the account bears a reflection on the memory itself. The concatenation of significant memories adds up to each individual’s history. One’s feeling of self and the emotional tone of the memory is determined to a large extent by its narration.

Hence, it seems patently obvious that the view and opinion of the social environment, particularly of the professional carers, have tremendous effects on the victim. To a large extent, these views and opinions will determine the person’s ability to develop or, on the contrary, to turn the wounds into stigmata.

However, Michel Hanus (“*La resilience à quell prix ? Survivre & rebondir”*, Maloine, Paris, 2001) while welcoming Cyrulnik’s work for awaking the conscience concerning the existence and the importance of resilience, tries to define its origins and processes.

According to Hanus, as with mourning, resilience is a process starting in the early childhood, developing and expressing itself throughout life. The history of resilience is also the history of trauma and its various destinies. It is the fruit of anger, rage and revolt against injustice : “ why me ? ”. Resilience is considered as a potentiality expressing itself in various ways according to the result of numerous interactions between internal (temper, firmness, defence mechanisms, history) and external elements in the subject’s relational world and individual context. Yet, this potentiality, not fixed, determined, nor permanent or invariable aims for an immediate result, produce an issue, a success. Resilience tends to control and master the negative effects of life’s events. It’s not just a form of resistance, but a reaction, the ability to have an effect on our own critical situations, in order to modify it. It is also a work of narcissical reparation as well as an act of communication, expressing respect, complaints, claim, scream, revenge …

Nevertheless, this author explains that the apparent victory over difficulty indicates the need, the necessity to close the effects of a psychic and narcissist plague, whose pain had to be anaesthetized in order to allow survival. Resilience, a developmental factor if any, could be a protective symptom as well as the very expression of the fathomless pain it is hiding.

In this sense, Hanus addresses a warning against a far too simplistic and idealistic concept of the phenomenon. Indeed, its triumphant characteristic, source of admiration, could well hide a gaping wound, susceptible of reappearing at any time.

Indeed, from Hanus’ point of view, the apparent victory on the difficulty also indicates the need, the necessity to seal off the effects of a psychological, narcissical damage, of which the pain has been anaesthetised to allow the subject to survive. In this sense, It functions as a symptom as well as a reaction formation.

The second warning that offers this author uses the aspect of temporality. Indeed, the qualities, the individual skills on which rely the resilience are not fixed and permanent. They modify, develop themselves and fade: *“ resilience not necessarily being a stable or unstable state, it testifies of the pursuit of dynamic physical activity; it is not the result but a mean and the progression never really ends. This secret affective wound is also likely to wake up and evolve”.*

Finally, Hanus will establish, in a bundle, the principal lines of strength of resilience, in the form of six hypotheses.

1) **the installation of resilience implies that the person that presents it has been confronted to one or several extreme situations that may have been a threat to their physical or mental life and having survived it.** This person has succeeded in overcoming the situation by being active, and without resigning. His/her self-esteem and confidence in his/her own skills will fortify themselves through the feeling of having survived. However, if surviving is necessary, it is not enough. Moreover, resilience has not waited for the trauma to establish its foundations. The latter will find their start point in the temperament of the person and under the effect of precocious relationships. The trauma would only reveal the latent skills and develop them. From this test, the person will come out victorious, stronger to some extent, but not unscathed, so long to heal is the moral wound.

2) **Resilience contains a sombre facet, a price to pay, a painful setback. Resilience is born from a conflict and its results bear the marks.** In this sense, it is a symptom and even if the sublimation and altruism hides this aspect slightly, the spirit of revenge and vengeance can turn against its subject. Resilience is the balm, the expression and the veil of distress that revealed it:

   "resilience seems to manifest its effects in the efficiency, the action, and success ; it is therefore more obvious in the expressions of social success. The hypothesis here is that its hidden, secret and unhealed facet is usually situated on the affective side, in the intimate affective life, which can only be obvious in the relationships with others… Cyrulnik's idea is that the resilient must set aside and deny the painful aspect of the traumatism in order to treat it efficiently… but when one must help the resilience, support the victims of trauma, accompanying implies helping the victim to put their past experiences, internal images and emotions into a narrative form to allow the person to bring herself closer with her past emotional experiences, to let them float to surface and let a state of present suffering return".

3) **Resilience is a work of revolt and the fruit of anger.** Facing the injustice expressed through *"why must I suffer this much?"* and *"why me?",* the subject reveals herself as capable to mobilize aggressive forces of revolt and anger to protect herself from a devastating pain. A sort of reactionary formation transforms the expected despondency into a glorious combat while a form of denial seams to trivialize the gravity of the traumatism. If these defences must be respected, so evident are the protective qualities of their function, the resilient subject will – when the time comes – realise the intolerable traumatic character of the event to really integrate it.

4) **The role of the family, in a form or another and at different moments in the life of the subject, is undeniable in the development of the resilience and in its various expressions.** Stable foundations, rich relationships but also a supportive climate during the catastrophes are factors of protection necessary to establish and develop the resilience skills. However, the misfortune, deficiency and need can also participate, in a movement of revolt or mending, to the development of similar mechanisms and skills.

5) **Chances of a satisfying relationship or preferably, for Hanus, the "encounter", be it durable or ephemeral, produced by the intersected destinies of two individuals is as important to the favourable future of the suffering person.** This encounter can take the form of a link likely to allow the establishment of solid foundations for the subject and a relationship of substitution. Sometimes it will be a punctual encounter where the person will feel recognized, respected and understood.

6) **Resilience is a psychological process analogical to the "narcissistic mourning" and establishes itself on the constitution of what Michel Hanus called "the aptitude to mourn".** As for the act of mourning, resilience necessitates cognitive skills (recognise a traumatic situation) to realise itself. As for mourning, resilience implies a arduous internal effort made of the internalisation of the relationship, the memories, recollections, fantasies, idealisations and identifications.

   "presented as a positive symptom, as an expression and an exit from the trauma, resilience implies a setback: its price, the enormous consumption of energy it demands and the exhaustion it leads to: an investigation needs to be done on the longevity of resilient people and on the quality of their overall life".

5.5. Impact on the handling

We have, here, seen all there is to see of this phenomenon and its effects in a complete and brief fashion. The methods of management of difficult situations, of stress or anxiety, like those taught in police schools or different services are becoming very useful and adequate daily critical situations. They are, however, probably insufficient, or even unusable, in the more extraordinary and abnormal dramatic situations. In this sense, in catastrophes, instead of management, it would be more pertinent to speak of “digestion”.

At the same time, the term “digestion” is not entirely satisfying. It implies that once it has been “digested” the even will be metabolised. Sadly, this does not happen. If the reader will allow my technological metaphor, things seem to go as if, at every critical event in our existence, a file is created. The latter, depending on its pregnancy as well as the elements that could support it, will either stay open, or stay as an active file “behind the screen”, or it will shut down. However, each new situation relating to it in any way is likely to reopen the file in question. In this sense, an event that has been integrated, or digested, is nothing else than a file that has not yet been reopened in a painful or disturbing way, but that is still likely to do so.

Conscious of the reduced range of our interventions and in coherence with the reflexions associated with the study of risk factors, the precipitating factors as well as the concept of resilience, we can revisit the “philosophy” of intervention and add a few comments to it.

PHILOSOPHY OR IDEOLOGY OF EMERGENCY PSYCHOLOGY

► the interventions in emergency psychology aim at a spiritual and psychosocial approach, they are not psychotherapeutic actions ;

As we have seen, the reactions are natural, no intervention has been proved to reduce the suffering or to present a preventive action. The task consists of rallying around the people involved in the dramatic events.

► the professionals practicing it know the basic principles of the interventions in this field ;

However, from the moment where a professional group is officially called to intervene in such events, it seems important for the members to know the phenomenon that are related to it and develop the skills like those aiming at not trying to make it a sector of therapy or proselytism.

► they are capable of using the knowledge assimilated in a critical and flexible way ;

The monitored training should give the intervening people the necessary skills to find an individual and adapted response to every situation. This means that the standardised responses are considered insufficient and non recognised for their universal aspect. A critical reflexion on our interventions is always necessary. Should we intervene ? Have we kept our place ? Have we done too much ?

►they know their own limits and are able to measure the consequences of a traumatism on themselves ;

The intervening person must be attentive to their own reactions (over-investment, conflicts with other intervening people, exhaustion and vacarian trauma) and the organisation that surround them should also watch over their well-being.

►emergency psychology is exercised only by professionals that do not depend on it financially ;

To succeed in maintaining a good distance with the accompanied people, to show they are able to stop themselves from doing to much, in other words to be able to focus their attention on the skills and resources of the person and his/her close circle, it seems essential that the intervening person can have other fields of occupation. If his profession should be turned exclusively towards the psychological support during the catastrophe, the risk would be great that they would look to be more useful, or necessary. If the majority of his salary is associated to catastrophes, the risk is great that he might try to legitimate his salary by doing too much and by seeing critical incidents everywhere.

►an approach aiming at the accepting the reactions ;

We have seen it, the reactions are considered as natural, but they can also be considered as means to protect themselves, confront or adapt. From this point of view, it would not be coherent to try and fight them or reduce them. However, the victim often suffers and complains from these reactions.

The intervening person, who knows the phenomenon associated with critical incidents and to the traumatic reactions, should be able to recognize the associated reactions in the person as well as in himself. To allow the person to accept his/her own reactions, one must give them meaning, explain them and often being able to bear the often surprising reactions, stimulating incomprehension when it isn't anger or disgust.

► the professional is present only for a time, instead of being considered a resource, he tries to mobilise those of the person, followed by those of his/her family and collectivity ;

The concept suggested here relies on the idea that, even though the person may have lost their contact momentarily with their skills, due to shock, the person is capable to face this. Indeed, during the period of the shock, every individual, every group or state, tend to be lived powerless, destitute and incompetent. Offering yourself as a resource contains an implicit message « we believe you are incapable of… ». This message, other than the fact that it is disqualifying, tends to lead the person to depending on you and can be stigmatising. On the contrary, our approach, associated in this point to the concept of « salutogénèse », considers that the individual is apt to face the trauma. Moreover, when exhausted or momentarily neutralized, his/her close circle or family, that are part of his/her natural resources, are the best suited to provide support. If the latter are not enough, his/her community can then take over.

We have understood that the feeling of powerlessness felt by the victim progressively extends to his family when the suffering seems to last too long. Substituting oneself to the help that a family could bring tends to increase the potential feeling of powerlessness in the family. Moreover, being able to help often produces a increase in self-esteem that would be a better gain for the family than for a stranger that isn't part of the natural environment of the person and of whom the responses could be differed.

In this sense, our intervention should be about the simple mobilization of individual resources (to allow the person to reduce their feeling of powerlessness, and establish a level of control) and of collective resources in which we will make appearances in (so that the victim can feel socially supported, by the people close to which she lives, emotionally).

►the professional must develop an ethical reflection on their intervention. He must be able to, for example, refuse a mandate associated with the intention of an organisation to get rid of their responsibilities concerning certain decisions and/or in certain poorly correct social situations ;

Intervening for anything is inadequate. Sometimes it even seems to be indicated not to get involved, notably in the situations where our arrival could be misunderstood, misinterpreted or unwelcome. Behind the « we are coming to help », there is an implicit « you need help ». Certain people could not need this help and would certainly not want to let people think that they need any social, psychological or spiritual support.

Thus, the intervening person cannot make the economy of reflection on the pertinence of the intervention as well as on the appropriateness to intervene.

►the approach is minimalist : do the least possible, but everything that is essential. Offer a presence and grant a maximum of command and control for the person and his/her close circle.

From all these reflexions taken from our knowledge of the phenomenon associated with critical incidents and traumatic reactions, thus the intervening person will have to do the least possible to leave the benefit of control and command to the victim, as well as the feeling of having been useful and helpful to the family.

The victim goes from a state of subject of their existence to the object of a fatal destiny, natural forces or the actions of individuals considered as malicious. If, to provide our support, we need to control the situation or the person, the latter will go from a state of object of a malicious person to that of a benevolent person. This is, naturally, a lot better, but it will not allow the victim to regain their state of subject (the necessary step to come out of the state of victim).

However, it happens that the people feel destitute and perceive their social fabric as is not able to bring them the necessary support. It is our task to make the diagnostic of the resources and fill in if the lack is too important.

5.6. Conclusions

Finally, and as conclusion, we will suggest the golden rules, of which the respect of could allow not to impede on the natural recovery and maybe diminish the risks of developing a pathological process.

1) we will avoid :

- bringing a new traumatism on the person
- transforming him into a patient, a sick person or a victim
- making the person dependent of us
- actively participating in avoiding mechanisms
- trivializing or minimizing the situation or the emotions felt
- criticising
- underlining the material loss

2) it is judicious to :

- allow the expression of thoughts and feelings, with respect and acceptance ;
- restore the self-esteem (by the valorisation of the role, behaviour and distinctive signs of the person)
- encourage the acceptance of emotions
- support the person in his/her processes (administrative for example)
- mobilize the individual, family, and if necessary social resources
- find a way allowing the victim to start his/her service, family function or social function as quick as possible.
- be attentive to the reactions that the person may present, a progressive deterioration of his/her state or his/her socio-professional situation for example
- leave a maximum of control and command to the person

3) remember that :

- A priori, in these situations reactions are natural.

It is not the situations, the behaviour or the act that define the possible effects, but the internal and external contexts of the protagonists linked with the critical incident.

6. FORMS OF INTERVENTIONS

6.1. Necessity of immediate and post-immediate psychosocial support

We realise how contradictory we may sound when insisting on the fact that these reactions are normal, not directly connected to mental illness, and are supposed to diminish progressively, while proposing professional psychological support. This psychological support is indeed rather controversial nowadays; we will comeback to this subject later. Let's return to the definition of the disorders, but this time to Acute stress Disorder from DSM-IV:

"The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilising personal resources by telling family members about the traumatic experience".

This means that the individual often tends not to be able to properly mobilise his or her usual coping capacities. In addition, dissolute by the sense of guilt and shame (most often reported in these disorders) as well as the impression that he or she suddenly became "crazy", the person presents strong difficulties asking for help. This last point is of extreme importance.

The individuals feeling the most distressed are the least able to take the required steps to obtain the necessary support either from family members or from professionals. In addition, often, when the person is able to cope within the family or among friends, after a stage of interest and curiosity, which seldom lasts longer than a couple of days or so, those friends begin to show their own avoidance reactions, using expressions like: « You must forget, just pretend nothing happened ». They tend to minimise or rationalise the situation. They simply cannot stand any more. They themselves feel powerless and helpless to soften their loved one's pain. In doing so, they make the survivor feel unappreciated and misunderstood till he or she ceases to talk about the experience.

For this very reason, we think that the practitioners in this field (psychiatrists, psychologists, chaplains, adequately trained social workers or other profesionnals) should slightly modify their usual procedures in being proactive where a critical incident is concerned. What's the point in waiting in a comfortable practice for a person who might never find the strength to call? Thus, we believe the professional should take the first step, with a more or less early contact or intervention. Now, here again there are disagreements among professionals, concerning the onset of the intervention as well as its form. Indeed, some questions arise about the relevancy of early intervention as well as the efficiency of the most common practice, the debriefing. To be more specific, psychological debriefing was often kept for the intervention staff, whereas usual therapeutic settings generally offered to survivors. Moreover, some recent papers reported poor or even negative results concerning debriefing with emergency personnel. Our experience does not support this assertion and we don't fully share this point of view as will be discussed later on.

6.2. Different types of intervention

The historic development of emergency psychology started with debriefing methods. As we shall see later, this method was designed exclusively for rescue workers. The method evolved, to focus (with a greater or smaller measure of success) on survivors, witnesses and their families. The term debriefing was then applied to different practices, at different stages of intervention. In fact, it would seem that using the same term - debriefing - for such a wide range of interventions may be confusing. On that basis, we suggest to use the term debriefing only to designate a relatively structured procedure, taking place for instance a few days after the critical event.

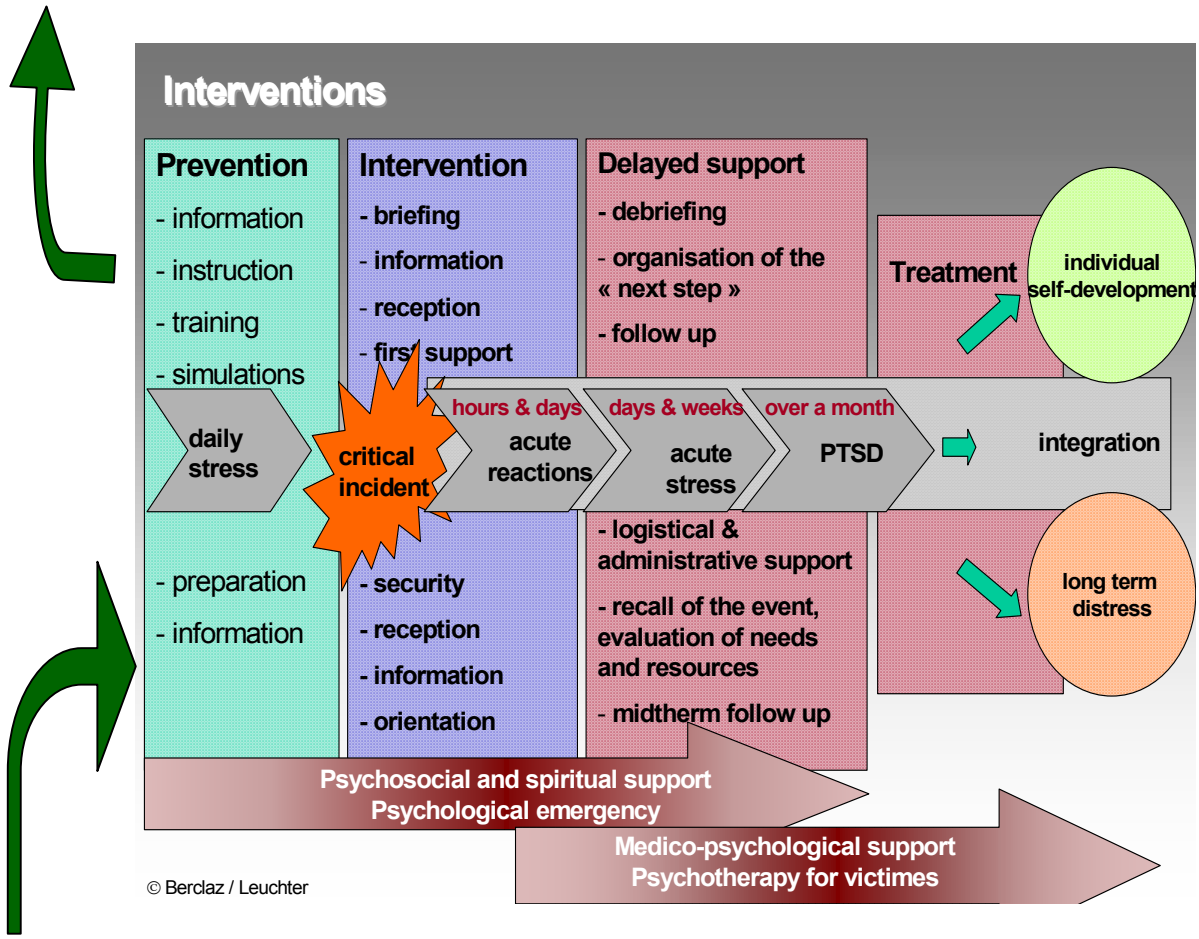
Moreover, it is easily understood that some authors consider debriefing as a procedure applied specifically to rescue teams. However, as we stressed above, survivors, victims and their respective families, witnesses as well as rescue workers are liable to show reactions. This being so, all these categories could benefit from such procedures. Although this practice is currently subject to some question in Europe, it is still broadly applied. Therefore, and in order to avoid adding to the confusion, we suggest the following terminology:

- **immediate psychosocial and spiritual support**, covering three areas:
  - intervention with survivors and witnesses;
  - taking in and providing support for survivors' and victims' families;
  - support and management of rescue teams; (defusing may be required during this phase)
- **verbalisation workshop on the event** (among which psychological debriefing), mainly for the survivors and the rescue team. Different articles emphasise that the process seems to be more effective if held several days after the critical event, and that a single session is often not enough. The facilitator should be specially trained and should have solid experience in dealing with groups. Nevertheless, recent researches seem to demonstrate poor or negative result concerning the use of this method ;
- **supportive relationship** within a limited number of sessions (kind of brief therapy sessions) are sometimes necessary for members of the different groups. In our experience, five to ten sessions are often enough to allow most of the individuals to mobilise their coping strategies. The first sessions can be very similar to a common debriefing, the remaining ones are often focused on stressing the eventual improvement, developing the coping strategies and working on the future ;
- **proper psychotherapy** is sometimes required. Indeed, for different reasons, we have to admit that some individuals' reactions will not diminish on their own. They will need professional help. But then again, it now seems obvious, that the psychotherapist must be specially trained in specific methods developed for treating Post-traumatic Stress Disorder. In other words, the usual psychotherapy might not be sufficient and the risk of considering the reaction as a depression or any other anxiety disorder is too high.
- **interventions in context,** work with networks (family, community, school, church, etc.) to mobilise residual resources. Such an approach may be adopted in most situations; for large-scale disasters though, when the domestic structures are overwhelmed – or no longer there – and where individual medical-psychotherapy is all but inexistent, it appears as the only operational method.

Emergency psychology as support to the people victim of a critical incident start before the occurrence of any event, by preparations and information. When dealing with critical incidents, immediate and delayed support, as well as, sometimes, midterm psychotherapeutical support must be intended.

If the population as well as the professionnals involved both might benefit from a support, this support has to be of a different kind and generally will be offered separately :

Support offert to the professionnals (rescue and support teams)



support adressed to the victimes, witnesses and both their families

Tasks of the psychosocial and spiritual support :

• **security** :	secure the intervention
• **talk** :	connect yourself to the victims
• **protect** :	reduce the stimuli (horor, media…)
• **support** :	offer a structured and respectfull support
• **if necessary** :	organise a more important psychosocial and spiritual support, as well as a midterm follow up.

- introduce yourself (name and organisation),
- explanation and orientation concerning our tasks,
- inquire about the person current state of health,
- answer the specific needs in security and comfort,
- gather the necessary information,
- provide clear, verified and useful information about the event, the organisation and the follow up,
- show visibility, availability and accessibility,
- take the name, address and phone number of the persons contacted,

Intervention's tasks and objectives :

- **evaluation :** **of the situation**
  of the people's state and reactions
  of the immediate needs
  of the ressources
- **resources mobilisation :** **1) individual**
  2) family
  3) and social
- **collaboration with different rescue and support teams, community and authorities in order to negociate constructive decision ;**
- **mid- and longterm contacts and follow up ;**
- **evaluation of the intervention.**

- write their individual contacts (victims or survivors wanted, family…)
- reduce confusion,
- favour and encourage autonomy,
- reception and support,
- evaluation and mobilisation of the individual and collective resources,
- evaluation of the distress and its consequences,
- favour and encourage the natural support between the victims and their families..

Checklist for the immediate response (*)
After the alert

- ☐ Concentrate, evaluate the situation. How do I feel ? Am I ready for an intervention ?
- ☐ Organisation of the professional and family environment.
- ☐ Choose appropriate suit and shoes.
- ☐ Identity documents (legitimating card from the organisation, identity card, driving licence).
- ☐ Medication (for personal use only), flashlight, something to write with.
- ☐ Communication means – mobile phone with charger.
- ☐ Handkerchiefs, chocolate, candy or other.
- ☐ Glance over and take the documents/checklists with you.
- ☐ Leaving straight after the call, organise the most adequate mean of transport to the contact point.

After the arrival at the contact point

- ☐ Find verified information with the caller or the coordinator of the intervention.
- ☐ Who are the affected people ? (number, culture, language spoken).
- ☐ Who is responsible for what ? (organisation structure of the intervention)
- ☐ What is my mission ? What are my skills for this intervention ?
- ☐ Provide a telephone list and a contact list.
- ☐ Stand back and keep it that way.

During the intervention

- ☐ Less often means more.
- ☐ Preferably act with restraint – no « aggressive assistance ».
- ☐ Listen rather than speak.
- ☐ Let the affected people come to you, simply be present and show accessibility and availability,
- ☐ Meet the needs of the accompanying persons.
- ☐ Support the person in his/her active search for solutions.
- ☐ If necessary, suggest alternatives.
- ☐ Beware of own limits. Ask for support early enough.
- ☐ Do not transmit information that has not been verified. Respect the rules of official statements.
- ☐ Do not forget that in exceptional situations, any behaviour can be expected.
- ☐ Take your own needs seriously (rest, drink, eat, be supervised, obtain information, etc.)
- ☐ Do not make physical contact with the affected people without their authorisation.
- ☐ Take note of the names of the accompanying people as well as the principal actions carried out and what has been agreed.
- ☐ Respect the confidentiality of data and the protection of private life.
- ☐ Warning : I am part of a team – not of an uncoordinated personal action.
- ☐ Regularly take contact with the direction of operations – situation briefings and reports.
- ☐ No contact with the media without the consent of the direction of operations.

After the intervention

- ☐ Take note of the principal actions and tasks not achieved in the intervention report.
- ☐ Liaison discussion when someone takes over.
- ☐ Discussion / meeting on the intervention by an intervention group.
- ☐ Signal the availability of the intervention groups that will take over.
- ☐ Use the possibilities of defusing and debriefing.
- ☐ Do something good for yourself (enjoyable).
- ☐ Be aware of the state in which you are in – ask for support if necessary.
- ☐ Put an end to the contact with the people being handled.

(*) inspired by the CFF/SBB Care team manual (Berclaz M., Braun U., Bucher F., Leuchter M.).

6.3. Immediate psychosocial and spiritual support

The (Swiss) Federal Office for Civil Defence, on the form it uses for immediate psychological support (9406-814-02-f) considers that this type of support is the best way to help people suffering from acute psychological distress. The form notes that, in critical situations, the immediate objective is to save lives, place people in safety and provide emergency medical care. The document also points out that equal attention should be given to psychological as well as physical functions.

The Swiss Civil Defence also establishes three basic principles : **proximity** (providing care on the spot), **speed** (intervening as soon as possible) and **simplicity** (simple method, no psychotherapy). Furthermore, it sets out a set of ground rules for practices and behaviours that could be translated today as :

State your identity	Introduce yourself and state your function. Ask those needing help to introduce themselves.
Stay with the victim	If possible, stay with those in your charge. If you must leave, make sure another rescue worker takes over.
Show your sympathy, your feelings	Do not try to minimise or "brighten up" the event.
Make the victim feel protected, safe	Protect the injured and their families from prying on-lookers. Try carefully to establish physical contact : hold their hand on their shoulder, for example.
keep the people involved informed	Inform those involved of the steps taken to control events as well as measures affecting the victims. Always tell the truth, do not try to entertain false hopes.
maintain an open dialogue, listen actively	Maintain an open dialogue. Listen actively and encourage people to express their feelings. Do not discuss accountability.
help victims to take their own responsibilities	Get the victims involved in practical, every day tasks to validate their sense of self-reliance.
follow-up on psychosocial and spiritual support	With the victims, look among their networks (family doctor, minister, relatives or acquaintances) to indentify further support, once things return to normal. Leave a contact number (e.g. a support unit).

Instructions regarding behaviour to follow with individuals suffering acute psychological distress :

Situation	Rescue workers' behaviour/response
Uncertainty	Resist the temptation to give reassurance when no certainties exist.
Overwhelmed, disoriented, feeling of de-realisation	Establish clear structures, give a sense of security, more by actions than by words; "sort" the issues, clarify one at a time.
State of shock, paralysis speechlessness	Be present while maintaining a certain distance.
Fear, anxiety	Allow verbalisation, listen attentively.
Agitation, hyperactivity, panic	Do not let it take over, stay calm, try to appease by ones behaviour rather than by speech.
Rejection of reality, denial of the event	Try to understand, do not contradict or rectify a perception of events.
Distrust, rejection of any assistance	Try to understand, do not take it personally do not impose yourself.
Anger, looking for culprits	Put up with aggressiveness, do not confirm accusations nor defend those who are blamed.
Guilt feelings	Allow these to be expressed, try to understand, do not attempt to rectify immediately.
Self-aggression	Try to protect the person from her/himself, using force if necessary to prevent self-inflicted harm, take the person to a calm and isolated spot.
Run-away tendency Wish to escape	Try to reason with the person, to convince her/him to stay or give in; however, do not let him/her drive a vehicle if not in a fit state to do so.
Asking why	do not answer, but do not remain deaf to the cry of distress behind the question, resist.
Weeping, shouting, Sadness, deep pain	allow the pain to be expressed, offer security and protection, an attentive and reassuring presence.

The (Swiss) Federal Office for Civil Defence's source for this table is: R. Albisser, Seelsoger (chaplain), Lucern, 1998.

Thougts on the theme of “listening” *

1. Adapt to the interlocutor

Take in account the fact that your interlocutor is in a particularly trying situation. Remember, however, that to fulfil your mission, you need empathy and not pity.

2. Do not speak

We cannot listen when we are talking. The presence is often the most appropriate form of communication.

3. Put your interlocutor at ease

Create a “relaxed” environment. Pay attention to your posture. Offer something to drink to or to eat.

4. Show that you want to listen

Show the person in front of you that you are really interested in what he/she has to say. If you don’t understand something, ask questions.

5. Move sources of diversion aside

Shut the doors, the windows. Switch your phone off. Don’t do anything else – for example, fingering files or drawing.

6. Be patient

When you are confronted with an interlocutor that seems in great need of communicating, do not lose patience. Instead, also leave spaces of silence. He/she must not feel that you are hurried by time.

7. Control yourself

Try and stay calm, even if you don’t agree with what is said for the moment. You will certainly have the opportunity to give your opinion – as long as it is necessary…

8. Do not let yourself be provoked by reproaches or criticism. Stay calm

Tell yourself: “I have a mission to fulfil and this is what this is about”

9. Ask questions

This encourages the interlocutor and proves your interest. Open questions will allow him/her to put in words what they feel and think.

10. Again: Listen

(*) from the CFF/SBB Care Team Manual (Braun U., Leuchter M. & Berclaz M.).

6.4. Defusing and debriefing

In order to understand these post-immediate intervention methods, it may be helpful to grasp the underlying myth:

the term – debriefing – comes from the military, more specifically from the air force. Indeed, before every mission, a squadron is assembled for a “briefing” session; a meeting held in order to describe the mission, define the target and assess the characteristics of the intervention. After the mission, the squadron assembles once more to analyse the intervention, evaluate its impact, note the difficulties encountered and its particularities, this is a “debriefing” session. This practice spread not only to civil aviation, but also to other emergency situation professionals. Notably among the fire fighters, probably initiated by Mitchell at the end of the 70’s, this practice takes on a new function. It is observed that the emotional experience of practitioners deserves further study. Here too, with varying degrees of success, technical debriefings evolved into psychological debriefings.

Still, to comprehend the phenomenon fully, one must be aware that this practice arises in a very particular environment – a “para-military” culture – and is designed for established teams working in critical situations virtually on a daily basis. The practice is repeated as many times as necessary. It is structured in specific phases, probably because the “procedures” or protocols are the way things are done in that type of culture and in similar situations (drill in automatic responses in order to remain operational in situations where thinking will most likely be impaired) and also because of the underlying cognitive-behavioural approach.

Transposing this practice to other individuals, less experienced people, who have not confronted this type of situation as often (survivors, witnesses) was not without difficulties. For instance, it is noted that often immediate debriefing is not very effective. Initially, it was recommended that one should “sleep” on the event, then wait 24 hours, later a further 48, 72 hours. Ultimately, it was decided that for non-professionals intervention should only be taken a few days after the event. However, it was observed that something should be done in the immediate aftermath, thus defusing appeared.

Likewise, in the attempt to adapt debriefing to the population at large, it gradually emerged that a single session often was not enough. Indeed, it is worth stressing that single sessions, which in the case of professionals will be repeated many times, cannot have the same impact on the civilian population which will benefit from only one, then to be left “out in the cold”. Hence, the practice usually followed in French-speaking Switzerland involves : one on-site intervention (possibly including a defusing session) followed by one or two sessions covering part of the practice and goals of debriefing.

It is worth recalling that the aim of these practices is not to erase reactions – which would be quite unrealistic – but rather to attempt to mobilise the individual and collective resources available. Increasingly, it becomes obvious that follow up help is often required : five to ten sessions with a specialist for example. For lack of a better term, we shall call this method “supportive relationship within a limited number of sessions”. In fact, these are conversations, over a period of various months, focused on the specific situation, but more importantly its consequences. It consist in accompanying the person and, if necessary, assist that person in developing his/her coping capacity as well as operating current problem solving.

Lastly, if we were to draw a distinction between defusing and debriefing, we might attempt a comparison along the following lines :

defusing	debriefing
The initial defusing session is a relatively brief interview after a critical incident.	A psychological debriefing session is an in-depth interview held after a dramatic event.
Defusing is geared to “defuse” (relax) a potentially explosive situation.	Debriefing aims to trigger the process of integration of the tragic event.
The initial defusing session is held in the immediate aftermath or the hours following a disaster.	Debriefing sessions are held in the days following the critical event.
Quite simply, defusing aims to cope with short-term reactions – a state of shock – and returning home.	Generally following a more structured approach, it deals with medium and long-term reactions to the event.

Defusing

Mitchell has define defusing as a small group discussion focusing on the potentially traumatic experience, shortly after the critical incident (best between 8 to 12 hours) and organised in three stages : introduction, exploration and information.

- ► introduction propose a guide line aiming to grant security and harmony in the process;
- ► exploration stage allows the participants to talk about the events;
- ► information stage aim to orientate the participants concerning the possible reactions.

The Swiss Federal Office of Civil Defence (in its leaflet 9406-814-03-f) describes defusing as “in theory, an abridged version of debriefing. The difference is that defusing takes place immediately after the intervention and that it does not go into such emotional depths. Defusing gives those who have just taken part in an intervention during a traumatic event, a chance to express themselves briefly on what they have been involved in, until they have time to analyse their experience in depth.”

According to the Swiss Civil Defence (OFPC), its aim is to diminish the intensity of reactions, to put them in perspective, share information about the event, set up a social network to avoid people involved being isolated and to assess the need for follow up treatment (i.e. debriefing).

Debriefing

Debriefing sessions are, above all, social events. They put an end to a dramatic, extraordinary situation, and to the chaos it causes and they signal the beginning of a reconstruction phase. As such debriefing is a **ritual,** an initiation rite. At these meetings participants may verbalise or listen to others verbalising the sequence of events, turn it into a recital, a story that may become part of their Life Story.

When debriefing session are conducted well, feelings and emotions may be expressed. However, it is essential not to create a new trauma or increase the original trauma. Avoiding, holding back emotions that are difficult to control, is a defence mechanism. This is a useful defence, probably a necessity, which should not be brought down at any cost.

In order to develop a reflection on intervention, we present hereafter « *Debriefing Red Cross Disaster Personnel: The Multiple Stressor Debriefing Model* » from K. Amstrong, W. O’Callahan and Ch. R. Marmar (1991). This article describes the disaster relief efforts in San Francisco and Oakland, during the 1989 earthquake, made by Red Cross workers and the debriefing which was provided to these personnel. The Mitchell’s Model for Critical Incident Stress Debriefing (CISD, 1983) is described and a modification derived from this experience is proposed: the Multiple Stressor Debriefing Model (MSDM).

At the time, authors have reviewed five intervention models: Crisis Intervention (Cohen and Ahearn, 1980), National Organisation of Victim Assistance Debriefing (National Organisation of Victim Assistance NOVA, 1987), Didactic Debriefing (Dunning, 1988), Critical Incident Stress Debriefing (Mitchell, 1983, 1984, 1986), and Psychological Debriefing (Raphael, 1986). They quote from Mitchell (1983):

A critical incident is defined as « any situation faced by emergency service personnel that causes them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later ». The goals of stress debriefing are « to protect and support EMS personnel and to minimise the development of abnormal stress response syndromes which may cause loss of time and effectiveness at work and problems within the family ».

Four separate types of debriefing are defined which take place at different points in time in relation to the disaster:

- **Debriefing on or near the scene** is generally provided in situ. The « facilitator » brings the rescue teams to discuss their feelings regarding their work. The workers are then made to return to their tasks or reassigned to a less-stressful role if necessary.

- **Initial Defusing** takes place within a few hours after the incident. It is meant to lead the staff to relax in an atmosphere of mutual support and discuss their feelings regarding the event.

- **Formal CISD** is a 7-stage process led 24 to 48 hours after the incident. It is structured and can last 3 to 5 hours, and

- **Follow-up CICD** takes place if needed when unresolved material appears to impair the participant's ability to function. It can be conducted individually or with a group.

Finally, Amstrong, O'Callahan and Marmar, in this article, propose a different model, based on necessary modifications due to differences in situations and populations. This model, the Multiple Stressor Debriefing Model, is structured in four stages:

Debriefing : formal CISD	The Multiple Stressor Debriefing Model
The introductory phase: the rules of the debriefing group are explained. It is made clear that the process is not a critique of the intervention, but rather a supportive event in which members both express their feelings and listen to each other. The fact phase: where the members describe what they saw, heard, smelled, touched and did during the operations, in order to process their experience. The thought phase: where the members are led to express their first thoughts in reaction to the most stressful elements of the situation. The feeling phase: the group discuss the emotional reactions about the incident. Questions about how the individuals felt at the time and how they feel here and now are treated. Previous experiences are discussed. Everyone is brought to express himself. At this point, the members are asked if they present particular physical or psychological symptoms since the stressful situation. In the sixth phase, the facilitators teach the group about Stress Response Syndrome and explain that it is typical and normal to react when exposed to a traumatic event. The final phase: re-entry, loose ends are tied up and outstanding questions answered. Referral information is also provided to members who feel they might benefit from additional counselling. .	Disclosure of events. Allows the staff time to discuss several incidents which affected them. This process is meant to increase the group's cohesion, regardless of the variety and number of individual experiences as well as the long hours of intervention. Feelings and Reactions. Feelings about incidents can be aired. A blackboard is often used to write down different member's feelings about the disaster. The facilitators emphasise the « normality » of the various reactions and the beneficial effect of talking about the whole experience. The authors mention, for instance, how much the victim's dissatisfaction expressed concerning the relief efforts may be distressing for the workers. Coping Strategies. Normal and pathological responses to stress are discussed. A discussion develops on how to protect oneself while still in a stressful environment and how to deal with the return home. A certain number of coping strategies are recommended, such as : exercise, good nutrition, breaks from work, engaging in relaxing activities, sharing feelings with co-workers, participating in staff meetings, staying in contact with family and friends, and using methods which helped relieve stress prior to the event. Talking about how members of the group coped with other disasters helps in identifying ways for the group to best cope with the current one. Termination. The development of close relationships through disaster work is inevitable. At this stage, it seems important to discuss the positive aspects of the relief operations as well as to say good-bye to one another. The transition to home is treated here again, as responses to the current stress may be delayed and appear later on at home, and because other professional and family stressors slow down the processing of the recent event. The need to continue to talk about the experience after returning home is emphasised. Follow-up individual or family counselling is suggested for those who continue to present strong reactions.
Mitchell, from the " Précis de victimologie générale" (1999).	Amstrong et al (1995)

The authors set forth a series of interesting recommendations :

► The aims, rules and stages of the session must be clearly explained at the beginning of the meeting.

► The leaders must be prepared to be verbally active throughout the procedure. They must take great care in managing the high level of anxiety. They are responsible for the quality of the "restraint" they provide when sensitive episodes are explored. It is important to assess the members' capacity to cope with this level of anxiety, and, if required, emphasise the didactic aspects rather than the difficulties.

► As this procedure takes place just before leaving the site, it is important that there be a relaxing atmosphere and comfortable facilities.

► Leaders should gather as much information as possible regarding the specific jobs of each sub-group (before the debriefing session). Knowledge of these tasks and close contact with the workers during the intervention, allow for stronger cohesion to develop among the members of the group.

► Debriefing session based on the MSD model work better when moderated by two co-leaders :

managing the impact of trauma is taxing, thus problems may be defused through shared leadership; complementary personalities or role sharing, for instance: one leader dealing with thought processes, the other with emotions, can make for more effective group dynamics; although debriefing sessions are not group therapy, transfer and counter-transfer dynamics cannot be excluded. Co-leadership may be a factor diminishing the perverse effects of such dynamics.

► It would seem advisable to separate workers from management in different groups, in order to avoid potentially negative factors related to individual's perception of authority, for instance.

► Communications between leaders and mental health workers must be clear and unambiguous, information should be transmitted regularly.

► The leaders must be able to create an atmosphere conducive to a discussion about the events. They must be able to avoid that members of the group feel criticised for their actions or reactions.

► It is essential to discuss the positive aspects of the experience. This contributes greatly to the integration of the events in their lives. However, leaders must be wary that this may be used as a ploy to avoid discussing problems they encountered or sensitive issues.

► Debriefing should be strongly recommended but never made compulsory. Individuals have many means to cope and to deal with difficult situations.

► Individual or group informal meetings (defusing sessions) may be offered to those presenting symptoms of acute stress. If necessary, these individuals should be referred to specialists.

► Debriefing sessions should also be organised for the team who lead the debriefing sessions.

A careful study of the concept of debriefing leads us to conclude that there are ultimately two broad categories :

■ clearly structured debriefings, and

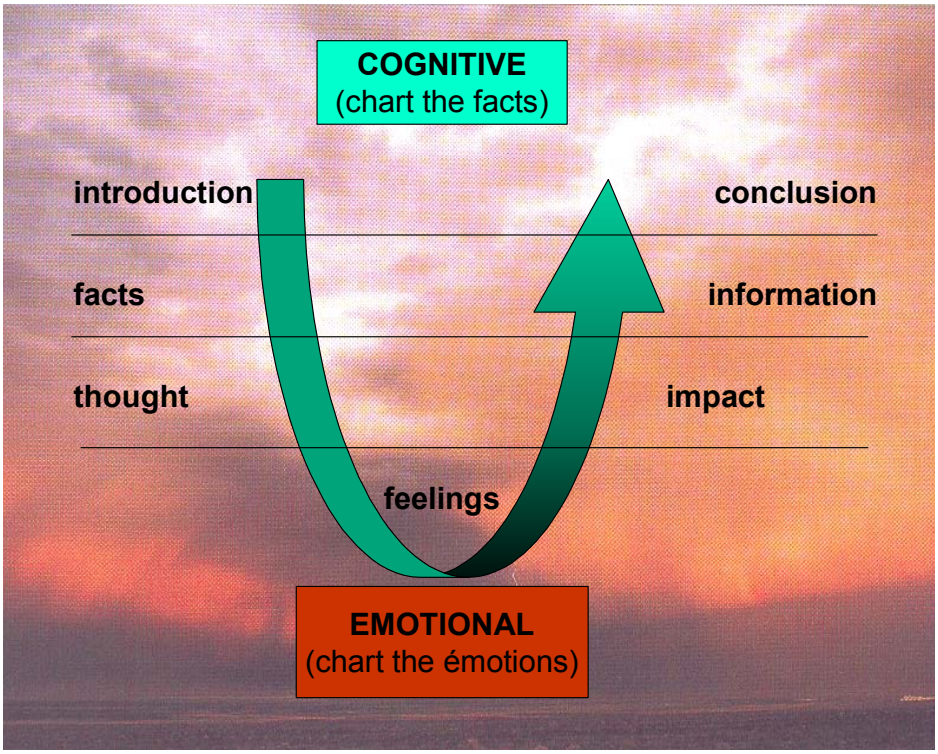
■ more loosely structured debriefings.

Structured debriefings :

are all based on the Mitchell basic model, introducing greater or lesser variations, additions or specificities and organising the stages or phases in a variety of configurations. As stated above, the aims of the different phases are posited on two main elements:

a) The first, the corporate culture (para-military and rescue worker) is designed for the facilitators (debriefers). Protocols or procedures must be developed to enable the leaders to cope with their stress;

b) The second, designed for the participants, relies on the cognitive-behavioural approach, heavily structured in its own right. The division in phases is geared to allow for emotions to surface progressively, while trying to avoid excessive unsettling (re-victimisation, loss of balance), in order to bring the participants gradually back to a certain level of calm and serenity. On this point, the Swiss Civil Defence (OFPC) explains that these sessions are designed to ensure a smooth passage from facts to feelings, to ultimately return to concrete facts, thus completing the circle. This agency suggests the following representation :



Unstructured or more loosely structured debriefings :

aim to allow for the free expression of words and emotions. Here we find the three T rule (“tears, talk and time”). These approaches emphasise the need to respect each person’s rhythm. They attempt to avoid revictimising the person, which may occur when one tries to make people express emotions at any cost, when one tries to “break down” defence mechanisms.

Often, because of these very approaches, doubts are cast on the appropriateness of group debriefing for people not belonging to pre-established relief teams.

From this overview, it appears that these methods differ both in terms of their historical development and of their context (corporate culture, psychoanalytical underpinnings). Lastly, clinical experience seems to show that practitioners must constantly adapt their work to the given situation, to certain prevailing characteristics, to the environment as well as to those for whom it is designed. For instance, opting for group or individual sessions will depend both on the practitioners training (used to working with groups or not) and on the atmosphere or the type of predictable relations between potential participants. Thus, in the aftermath of a collision, the decision to include the bus driver in the passenger group or not, may depend on the practitioner's feeling as to whether the former might be seen as responsible for the accident or, on the contrary, as having saved the lives of the survivors thanks to his reactions.

Likewise, the decision to intervene immediately or not, the depth and potential scope of the therapy, will depend on the state of the participants, on the type of reaction they are having (state of shock, non-realisation, or apparent ability to take in the event) and on the time available, the context, various other constraints (needs of the police investigation, various other procedures, need to get back to work, etc.)

Finally, the legitimacy of intervening as well its form will depend on the evaluation of the needs, the diagnostic of the resources (individual or collective) and various variables of context.

.

6.5. Objectives of intervention

According to a cognitive model of the trauma, it is advise not to insist on talking about a dramatic event for about a period of four weeks after it occurrence, in order to respect the natural process of memory. This standpoint deserves an acute attention for it might modify seriously the content of our future interventions.

Meanwhile we must admit that the organisation of the psychological debriefing into seven or four stages, as well as the progressive expression of facts, thoughts and emotions are not the most important points. Indeed, it seems far more relevant to study and adhere carefully to the technical aims of this method. On the other hand, one will probably realise that in proceeding this way one might reach these aims regardless of the stages. As indicated above, when treating the elements that cause the stress reaction, we identified confusion, emotional overwhelming and powerlessness or helplessness. Our method appears very simple. **Everything done in our interventions is supposed to have an effect on these elements. In other words, any action should be designed and able to diminish at least one of the above elements** (confusion, emotional overwhelming, powerlessness) **without increasing the others**. For this reason, we will list below a certain number of methods to fight the different causal factors of the stress reaction.

However, before we suggest a series of suggestions, advices, attitudes and reflexions, we must repeat how fundamental it is to take, at all times, the time to reflect on the range of our intervention, on the effect it is likely to have on the medium and long term for the beneficiary of the care. Lastly, we want to signal here, that what it written on our interventions must be considered in the cultural context from which it is taken. One must not impose a method, but, with the development of skills and knowledge, engage contact with the other, for an experience from which everyone would come out grown. It is useful, at this point, to repeat Christian Petel's warning:

"*The mediator should be an element that intervenes at a given point in time and in history, preoccupied by the notion of the victim as subject, the consequences of the traumatised person and the intervention suggested. In all interventions, one should keep in mind his future departure, his own absence. The mediator has to support and maintain confidence in the individual and collective resources of the people victimised*."

CONFUSION

As noted previously, the critical incident bursts in the life of the person. Often unexpected, it changes the daily life of the person. It is rare to have a representation of it in our history, it is just as hard to "re-know" it. We have difficulties in understanding it and we do not have any referential to present adapted actions. The event, like the system in place to respond to it, bathe in chaos. The person suddenly involved in such a situation will probably feel a reaction of shock, he/she will not completely realize what is happening, and progressively will present memory disorders and show a difficulty to concentrate. This state of confusion will increase to such a point that it is hard to cognitively integrate the event, to understand it. Experience shows that the people involved in such situations express in an extremely strong way their need to understand. It is often clear that it is the difficulty to accept what is behind this need to understand. It is imperative to try and respond in the best way to this need and allows the decrease of this state of confusion, while respecting the fact that it can also be a way for the people to protect themselves from a brutal realisation of the horror. For this, we recommend a series of simple actions:

Introduction and presentation : where the facilitators introduce themselves as a person, as a member of a team and an organisation, and state their mission and who mandated the intervention. This is a fundamental point. Imagine that the surviving person is the "object" of a malicious person or situation. At the moment of the rescue, an army of rescuers, doctors, policemen and other benevolent people but taken by the emergency, have talked to him/her and given him/her instructions and placed him/her here or there. The surviving person finds himself/herself the object of the intervening people. At the first moments of the encounter, presenting oneself, but more importantly being interested in the person, corresponds to putting and end (symbolically) to the situation. The person takes back a part of the control. The point is to **orient the participants concerning the kind of intervention involved**, explain its scope, setting, context, content, duration and objectives as well the necessary group functioning rules.

Information : whenever possible, the facilitators have to gather the most information about the event, its causes, development and possible effects on the future. It is strongly recommended, once again when possible and relevant, to invite authorities or management representatives for clarifications as well as specialists from specific fields (such as firemen, intervention teams, engineering specialists, officers in charge etc.) in order to **provide technical or organisational understanding** and answers to any questions that may arise.

Explanations, descriptions and clarifications : following the contextual explanation provided by the specialists, the facilitators gather the factual elements owned by every group members. Everyone has the opportunity to describe the content of his or her experience, anyone being the possessor of a fragment of the puzzle that is the global event. The participants have the opportunity to « fill the gaps », better understand the process, correct wrong impressions, all in all, to better comprehend the situation. The facilitators' mission consists of summarising, improving coherence and helping to organise thoughts. They may have to be rather active in offering guidelines. It might be very effective, when time at disposal allows for it, to start the narration from the hours preceding the critical situation, and terminate with the days following the event, till the day of the debriefing for instance. Indeed, distinguishing the before and during from the after, tends to diminish the effect of the confusion. It can sometime be necessary to **orient the persons in time and space**.

Orientation concerning the possible procedure : when organisational, logistic, administrative or legal follow-up are expected, explanations can certainly be helpful.

Redundancy : in order to fight the effects of confusion, one has to repeat information. It can be done orally (in expressing things in different ways) and visually (using a blackboard, flip-chart, transparencies, photocopies, diagrams or drawings).

Avoid mixing different events : as noted earlier, people tend to report previous traumatic experiences or link together the current event and previous distressing situations. The facilitators might have to help the participants to clarify hotchpotches and to distinguish the various elements. The suffering brought on by crises and traumas is a complex process that is not the result of the trauma itself but is also attached to its history and the chain of events. In return, the response in terms of counselling, should also situate itself in the history and chain of events. But during the meeting focus is put on the critical event itself.

Distinction between various feelings and impressions : the facilitators may have to support the participant in distinguishing between fears, needs and expectations for instance.

Reorientation of anger or rage : the traumatic experience produces feelings or anger, outbursts of rage and hostility. Usually these feelings are wrongly addressed and miss their target (displaced on a wrong element or turned towards the person himself). The facilitators can bring the participants to understand the phenomenon more clearly. The energy of anger and rage could be used to mobilise the resources, strength and responsibility.

EMOTIONAL OVERWHELMING

An attack on, or a threat to, the security or the psychic and physical integrity, tends to imperil the existential sphere of the individual. The first actions should be, without doubt, to offer shelter, promote security and provide for basic physiological needs.

Physical and psychic protection : the place and situation of the meeting should be, whenever possible, secure (and it is often not the case in chaotic situations such as disasters for instance). Sometimes it can be a place well known to the participant, and considered as reassuring, or, on the contrary, a place with no link with the critical situation. Warmth, drink and food often contribute to providing the feeling of security, in that they satisfy basic needs. It encourages a less formal and more friendly and relaxed atmosphere.

Security and comfort : security and comfort can be provided by the scope and setting of the intervention itself. Indeed, to talk about the critical event implies fighting against the mechanism of avoidance. Thinking about the horror of the event increases the psychic pain and awakens violent emotions. The context should offer sufficient security. The rules of the group process contribute to this feeling of security. The participants are gently invited to express themselves, without any constraint. They are brought to talk about their own experience. Non constructive criticism, hostility or anxiety outbursts should be carefully avoided. The main rule should be the respect and acceptance of everyone's feelings and points of view, but not all kinds of behaviour. The facilitators are responsible for this process and should stop the intervention if they are not able to ensure its smooth running.

To provide a « container » : in other words, the meeting should offer itself as a safe container able to welcome with respect anyone's reactions, thoughts and emotions. It should work as the function of « filter » described by S. Freud or the function of « container » developed by Bion. The participant should be brought to express their primary raw emotions and progressively to understand and maybe to accept them. This slow process allows to take some distance, to mentalise and thus to ease the integration of the experience.

The process of representation : it seems nowadays commonly agreed that when we are in a more intellectual sphere (thought, comprehension, cognition), we invest less in the emotional area. In this way, orienting the participant toward a more intellectual process allows for the diminishing of emotional overwhelming. This is, by the way, the strategy adopted in the Mitchell's CICD.

The slow progression from factual descriptions to thoughts to emotions is a kind of « desensitisation » technique. It is meant to allow for the careful treatment of the most sensitive elements. We could criticise this method for being too complicated and over-structured, thus deflecting from its primary function. In other words, we believe that it is of no importance to follow the stages strictly, the main point being the facilitators' capacity to diminish emotional overwhelming and allow the participants to contact, understand and maybe accept their own feelings. On the other hand, one must accept that this method can be rather effective for the latter.

Focusing on sensations and perceptions: this goes exactly in the same direction as the preceding point, except that it stresses the progression from the physiological, organic sensations to representation. Finally, whichever method is chosen to diminish emotional overwhelming, it is essential to allow the participants to revisit their experience on a bearable emotional level. In fact pushing the individuals to a level of anxiety or horror superior or even equal to the primary experience should be strictly avoided. Indeed, to fulfil its truly effective cathartic effect, the abreaction targeted should be gentle and progressive. A massive emotional outburst would only become a new traumatic situation, which would, no doubt, be counter-productive. In fact the very poor results shown in recent papers concerning debriefing might well be connected with procedures insisting more on reliving the experience than on the actual « digestion » of the event.

Normalisation of reactions: the various reactions described by the participants are discussed and can be explained. It is said that they are not, a priori, part of a pathological process. Sometimes, a positive reframing, stressing the function of the defensive mechanisms can be carried out. It can be shown how they might have allowed for survival or how they enabled « digestion » by delaying or slowing down the process to ensure the integration of the event. The facilitators have to find the proper equilibrium in order to neither bring discredit upon the participant by describing their experience as banal (which might increase their feeling of being misunderstood), nor to add to it, by dramatising the experience (which could cause a stress reaction that they would not have had without the intervention).

Focus on the representation: the process of psychic elaboration that allows the integration of the memory in an associative chain might need more than just verbalisation. It is sometimes necessary to choose, as a first step, another media, such as individual writing, drawing or any other methods mastered by the facilitators.

Definition of our own security sphere: everyone is guided towards developing a reflection on the elements considered to be necessary in order to feel secure.

Para- and non-verbal support: the majority of elements described till now appear to be rather factual. They consist of actions, points to be respected or avoided. In fact, clinical experience seems to prove that the success and efficiency of this sort of intervention depends as much on the respect of these various points as on a kind of attitude or even ability. In other words, and with the risk of using a cliché, it depends as much on the doing as on the being. The facilitators not only have to be warm-hearted, welcoming and understanding, but, in addition, they have to deal with their own emotions, reactions and defensive modes. Their ability to cope with the stress, and withstand the expression of distress and anger, in particular when addressed directly toward themselves, is important and seriously put to the test in such situations.

They have to present comforting and caring attitudes. They should avoid excessive contrariness such as hostility, conversely, over-protecting, de-responsibilising or even beatifying behaviour should also be avoided. It appears, in these sorts of situations where primitive processes might be involved, that verbalisation might not be sufficient. Indeed, verbalisation deals with processes and capacities belonging to a more elaborate level, which is not always accessible in situations of basic survival. In these conditions, para- and non-verbal communication have a powerful impact. Methods borrowed from hypnotic methods can be extremely useful in that they may have an effect on the more primitive levels.

POWERLESSNESS AND HELPLESSNESS

Accompanying the individual to contact and accept the feeling of powerlessness: the person has to admit the ineluctable facts. He or she has been the object of unavoidable forces (malicious individuals, natural elements, fate or destiny). In most cases, individuals involved in a critical situation experiment and express feelings of guilt and shame concerning what they did not do or on the contrary, the behaviour they presented at the time. They tend to reconstruct the event, explaining what they should have done and how it would then have been different. They feel guilty, shameful, dirtied, sullied and unworthy. The facilitators have to direct the participants through a **process which can allow them to pardon themselves**. Survivors tend to consider their own reactions as a strong vulnerability at best, and at worst as a weird pathology. Allowing ourselves **permission to feel and react the way we do** seems indispensable for the process of healing.

Positive reframing (modification of the feeling or representation): it has been shown in the fight against emotional overwhelming how some defensive mechanisms, generally considered as inadequate (such as being dazed or flight), can sometimes be interpreted as adaptative behaviour which enabled the survival. Such positive reframing, when relevant and acceptable by the individual, can be extremely effective, providing that it is not imposed but progressively expressed by the person itself, through the interaction with the mediator.

Mobilisation of resources: the facilitators encourage the participants to seek and gather their own personal and social resources. They can be found in the individual history, from previous experiences, especially difficult ones. Coping strategies as well as different ways to deal with such events are shared and discussed. A list of various personal strategies as well as group and social resources can be made within the group.

Allowing individuals a maximum of control and mastery: confronted with disconcerted people in deep distress as well as their own feelings of powerlessness toward past events such as human suffering, the caregivers tend to be hyperactive, over-protective and disresponsibilising; in other words, they do too much. By acting this way, there is the risk of increasing survivors' feelings of powerlessness, and forcing them into a relation based on dependency. The facilitators' mission is to allow participants to mobilise their own capacities, to allow a maximum of control and mastery over their own lives. The person should discover within themselves the strength not only to live with the consequences of the trauma, but also find in them the means and opportunity for personnel growth.

First and foremost, the interventions should not complicate nor risk adding damage or chaos, nor threaten the foundations that still exist but have been sorely weakened. Secondly, interventions should focus, as noticed before, on search, development, and exploiting of resources already present in the surrounding environment, and, to upkeep and strengthen already existing bonds.

This aspect appears to be very complex. Doing too much produces gratitude among survivors; they have the impression of being helped and supported. On the contrary, a slightly more distant and passive attitude on the part of caregivers, trying to stimulate the survivors' coping methods, generally produces anger and feelings of helplessness. On the other hand, an attitude of great expectation can be absolutely irrelevant when confronted with people unable to mobilise their coping capacities or even to ask for help. The caregivers have to find the right equilibrium between offering the necessary support and acting in the place of the survivors. Finding this right equilibrium implies, for the caregivers, the capacity to stand the impression of being "insufficient", to put up with the survivors' anger as well as to overcome their own avoidance mechanisms.

This complex situation might be one of the reasons why so many questions arise nowadays concerning the relevancy of early intervention as well as the efficiency of debriefing. Our belief is that we should offer early intervention where contact can be made and general support given, with the possibility of an initial defusing. Later on (after some days or even weeks, depending on the situation) a verbalisation workshop as described above, might be carried out. Sometimes it has to be repeated after a certain delay. Finally a discreet follow-up, where contacts are taken, from time to time, by phone for example, is useful for two reasons. Primarily it makes it possible for the caregivers to evaluate the healing process, to spot possible PTSD with delayed onset, which would otherwise escape diagnosis, and to encourage the individual to consult a private specialist if necessary. Secondly, clinical experience shows very clearly the positive effect of discreet follow-up on survivors and their families. Indeed, most of the time, survivors and their families as well as victims' families obtain early support, from professionals and from their social environment. But after a while, when things return to everyday life, they often feel forgotten, abandoned and unappreciated. We guess that these feelings might well have something to do with some delayed symptoms and late consultation among various practitioners. Phone contact shows them that they are not forgotten, that we understand the event is not so easily integrated and know they can still be in pain.

Finally, debriefing for instance, is to be considered as a method among others. This method shows its full potential for the mediator, far more than for the participant himself. Comprehension of the sufferings of others, at times expressed, at times inexpressible, at times even inaudible, are all achieved trough the experiences of the mediator. For the latter lies a high risk of misinterpreting the dialogue and actions of the victim. The consequences of the effectiveness of his listening ability and reactions require his full implication in the long term.

The professional should develop an objective outlook and intervention that will help the victim reactivate his residual resources through interactional collaboration. The rupture of relationships is indicative of the areas necessitating reparation and intervention; a therapeutic venue for reinforcement and support of existing relationships.

The mediator should have the ability to help the victim re-write his own personal narrative and repair a rupture. Relationships are not only founded on that which must be repaired, they are the medium through which that which must be restored can and will be. He should be the starting point for a reconstructive process, one that would integrate, through extensive collaboration, the distress and residual resources of the victim and those closest to him.

As noted above in Metraux's work, the period of ***frozen grief*** is necessary, it must be respected, showing respect for the right to be silent, respect for the unspeakable, the unutterable. *"To not hasten the outpour of words, the airing of memories held in drawers where layers of corpses, abuse and horror are stacked. We must set aside our curiosity, not ask, or even try to guess at the suffering undergone".* According to this author, it is best to wait and see, both in the case of children and of the parents. However, in his view this does not mean to do nothing, and he suggests several actions :

- acknowledge and state the injustices sustained, specifying that the pathology is social rather than individual ;

- acknowledge the visible symptoms as natural, stating that distress, the desire to forget, the inability to concentrate on a professional task or on school work are normal reactions to abnormal situations and in this way help individuals to regain their self-confidence, confidence in their skills, in their qualities and in their resources ;

- provide safety zones where the right to silence is recognised, but where it is understood that what is said will be listened to, acknowledged and cared for;

- give priority to grieving for present losses and traumas such as the loss of a guarantee of permanent shelter, of an undisturbed schooling, of a society devoid of ethnic divisions. To help the person and the community to resume their role as actors and authors of their future;

- build bridges between past and present, find common ground between the homeland and the host country, foster communications with family members who stayed behind ;

- provide parallel support for both parents and children;

- multiply the contact points, as a greater sense of belonging counteracts the effects of exclusion, of war, of violence.

Jean-Claude Métraux considers that the professionals in dealing with suffering have an enormous responsibility, since they have the means of rehabilitating the pain, establish it as a memory and therefore of *"healing the ethics that the craftsmen of wars and other violence attempt to tear asunder".* He thinks that it is not a matter of working out a means of survival or of developing a way of adapting to injustice, but rather of mobilising such resources as required to create a new sense and build a future in which "dreams are reinstated" as a driving factor.

While Cyrulnik considers that creating an historical account is a healing process, necessary to the construction of an individual or collective identity, he cautions the reader against abusive memory which can imprison one's past.

As an example, he refers to the proliferation of Post-traumatic Stress Syndrome and related risks that are diagnosed. One such risk he mentions is the use the victim or society may make of a given memory. *"A wounded person is justified in defending himself, but an encounter or a simple sentence may suffice for the victim to use his story to affect others, to make them feel guilty, to legitimate his revenge on moral grounds… If we dig into our past, we can all find something demanding revenge. Erasing the memory is no solution since this only lays the foundations for repetition. To surrender to one's past is a means of preparing one's revenge. Obliteration gives way to relapse, while abusing memory paves the way for deliberate repetition.*

Neither forget nor exploit : the only way to overcome is by understanding. To feel coherent and at peace, those who are wounded to the soul are compelled to narrate their ordeals in order to address a society which, after condemning them to silence, will push them to the fore and turn them into ideological weapons or pawns in a social transaction… But as soon as a victim has presented his account, it is whisked away from him and used to feed into a story unrelated to his. To defend himself, the victim can only tell his misfortunes, but he confronts an ever changing culture which constantly attributes a different meaning to the same event… Abuse of memory arrests the future, condemning the victim to repetition more surely even than its obliteration. To work on understanding the past, and not to exploit it, allows for a combination of meaningful memory and breaking away from one's past, which opens a door to innovation."

In order to illustrate the manipulation of distress, let us quote Maurice Hurni and Giovana Stroll ("Une défense perverse méconnue : l'exportation des conflits intrpsychiques dans la société. Par exemple: une campagne décervelante" *in Bulletin des Médecins, cahiers 25, 1997*). Indeed, the authors raise a very fundamental question about an official campaign in Switzerland, concerning violence within the couple. They consider its ideology as rather questionable, based on near delirious belief according to which violence is exclusively masculine, women being utterly deprived of it. This ideology does not attempt to understand the origin of such violence within the man and does not take into consideration either the history or the relationship. On the other hand, it is insulting to women, denying their very own aggressiveness, as well as any responsibility and finally the dignity to cope with it in a better way. In so doing, this ideology actually denies their status of human beings. The women are considered as irresponsible. The marital conflict - within this ideology - exists exclusively in one of the protagonists and beyond a seductive "you are angelic" statement, lies contempt, encouragement to distrust and projection.

Hurni and Stroll explain that such a campaign calls upon the meanest pulsions inside us, allows the emergence of violent feelings discharged directly on the scapegoat. It leads members of a society to identify themselves with a group officially defined as "good", in order to hunt out another category designated as "bad". In this attempt to master and control others (a typical pervert's behaviour), and as a pervert would do, it is an assault against the bonds, where love for one another and hope for improvement are considered as an obstacle to separation and social sanction.

Let us return to Cyrulnik. This author recognises that when “memories are fresh” there is a need to narrate the experiences to be able to control our feelings, to socialise the ordeal, to regain the feeling of being like anybody else. However, he lists some of the elements which may explain why some people shy away from speaking, from revealing their secret. Some such elements are:

- the fear of upsetting people, of spoiling an evening, of inflicting pain, making those who love us do our fighting;
- the fear of exposure to outside judgments, whether inquisitive or derisive, that society may use their pain either to put it into perspective, to make fun of it or to dramatise it;
- rejection of an intrusion on one’s privacy by society, attempting to force oneself back to normality;
- when abuse by the very persons who should have protected the victim (such as parents) is revealed, the fear of becoming an aggressor oneself, of losing the still beloved parents, regardless. And the shame of confessing what turns into a fault, or quite simply the shame of having been born to such parents.

Finally, though expressing one’s pain is undoubtedly part of healing, it is not enough to tell of one’s distress to make it all better. Such a belief would amount to believing in miracles, in the omnipotence of the will to heal. The calming, restoring - even liberating - power of words depends to a large extent on the empathy and on the respect the listener shows as well as on the share of accountability the latter imparts to the wounded person.

As we have seen above, the help provided to victims spreads on different levels from psychosocial and spiritual support (with reception, support, various spaces of exchange and ventilation) until the contextual approach and humanitarian support. As we have seen, the results of recent scientific researches go in the same direction, the debriefing on which we had put so much hope, has proved a little disappointing. In fact, it is here a stylistic device. Emergency psychology was looking for a standard universal method, that we could have integrated and reproduced in every situation and of which the efficiency would have been able to dispel the horror of the most dramatic experiences and the distress of human condition. It is our hope that is disappointed not the method. We realise today that the intervention is an action of which the efficiency depends on the objectives that we intend for it, on the choices of situations during which we apply it and our flexibility to adapt its form depending on the context.

With hindsight, authorised by experience, the efforts of adaptation of our interventions with individuals, with specific needs, resources and contexts, we have chosen the name of immediate and post-immediate support to our interventions. Amongst the tools at our disposal, we do have the debriefing, term that we keep for certain situations that seem to require it.

6.6. Limited number of supportive sessions

During the twists and turns of the development of this method of debriefing, it seems to stand out that not only is this an approach amongst others, but that the chaotic reality of the situation it is applied to require that it be able to take multiple forms. Indeed, the strong point of the experience in the field of psychosocial and spiritual support seems to be about the capacity to adapt. Every catastrophe situation, outside the chaos that makes it up, is so particular that it renders necessary the development of this adaptation skill. Yet this adaptation is also about the method of debriefing, leading us to giving it so many different forms that it requires that we question the pertinence of the use of such a term. We realised that a generic term should be created to designate the whole of what is likely to be suggested in the reception and accompanying of victims and reserve the term debriefing for the structured method applied amongst emergency professionals.

The history of debriefing has also showed that the attempt to adapt a single session to the population, we could only encounter disappointments. We then went on to three sessions (intervention on site, a debriefing a few days later and a last session in the following weeks). Naturally, these three sessions do not help the person protect themselves against the development of a potentially durable suffering, but this is purely a illusory objective. However, these interventions spreading on a certain period allow a better accompanying of the person in the first few weeks after the trauma. The social act of being preoccupied for the people in distress is much better adapted. Moreover, these few weeks (with a few additional phone calls) give a better chance at evaluating the mobilisation of the individual resources as well as those of the network.

Still, for certain people, our intervention ends up being superfluous or even counter-indicated, for others the reception and accompanying aren't enough. For the latter, and notably in the case of our collaboration with the LAVI centre (associated to a law concerning victims of infraction), we have developed a technique through five to ten sessions spanning over several months, and can go up to over a year. This technique has the advantage of offering an accompanying on a longer period; it's also an interesting alternative to psychotherapy and doesn't have the heaviness of certain of its social connotations. It isn't rare however that it opens on psychotherapy. We could even imagine that when it becomes necessary, this technique may ease the way into a psychotherapeutic process.

For most of us, this situation implies that one must globally adapt the psychotherapeutic techniques for each to the restricted number of sessions. Indeed, the psychotherapists are formed at least in one approach or one therapeutic school, and have developed a concept of health, a representation of therapeutic relationship, and they adapt their conceptions and acquired skills to the person, their context, and to the type of victimisation and especially to the limited number of sessions.

This approach lies midway between psychosocial support and psychotherapy. In fact, I cannot find a satisfactory terminology to describe the discreet accompanying limited as a certain number of sessions spreading over time and of which the objectives are mostly to offer support and mobilise the resources of the person and the network.

The term "brief therapy" corresponds to relatively well-defined approaches whether it be the brief therapy developed by Sandor Ferenczi in parallel to the works of Freud concerning the psychoanalytic cure, to the systemic brief therapy of Palo Alto and its developments, or even the psychiatric approach to brief therapy from the concepts of crisis. I believe that these various approaches cannot be applied without adaptation. They all share their criterion of choice: the capacity in the treated, to establish objectives. Yet the traumatised person feels disconcerted, in deep distress and often incapable of projecting oneself in the future. A big part of the process is to aim, at first, to establish the conditions that will allow the basic security that is necessary to the formulation of the said objectives.

In this sense, and always in the aim of satisfying this standard of intrinsic adaptability to the problem that occupies us, I believe that the approach used should be transtheoretical. I will try and describe here, instead of an ad hoc method, characteristics of a therapeutic relationship, characteristics inspired by the three categories of brief therapy mentioned above as well as by other techniques, such as the cognitivo-behavioural approach, the Gestalt Therapy, the transactional analysis or the relationship of help developed by the nurses in the psychiatric department. If I had to describe the general process, it would go as follows:

- the installation of an alliance, the recognition of a status of victim and of the distress that it implies as well as the establishment of a certain level of security;
- the affirmation of the position in a relationship (define what we refuse or what we wish and try to express);
- the re-instauration of a more balances relationship (name our needs and learn to negotiate);
- the definition of the problem: analyse the concrete difficulties of daily life;
- the definition of the solutions: analyse the attempted solutions and their results;
- the elaboration of objectives
- accompanying on part of the progression (objectives of life and process of mourning)
- the end of the intervention

The nurses, and particularly those treating mental health, have developed the concept of a relationship of help, defining the structure of this relationship as well as the attitudes and communication techniques attached to it. This approach notably inspires itself from Carl Rogers.

The rogerian thought is commonly accepted as open and non-dogmatic. It is that of a man who practices psychotherapy, and has elaborated a theory of the personality and relationship. His theory lies on the premise of the positivity of human development. Personality is considered as a tendency towards the integration of these different elements, the actualisation of oneself, and the relationships with others. This theory also lies on the unconditional acceptance of oneself and of others.

Rogers rejects the notion of pluralism of the personality, like the psychoanalytical pluralism. For him, the unit of a person is not one of structure, but a unit in a creative process only letting itself be seized in a “becoming”, an evolution. In this sense and at the moment of its apparition, Rogers’ reflexion presented itself as a living protest against the dominant trends of industrialised society and its scientific thought type. It was lived as a protest against society and the north-american science, often similar to certain dissident trends of psychoanalysis: Otto Rank in particular, written down, at that time, in a Marxist ideology and a somewhat fossilised context.

In this approach, psychotherapy is nothing but an encounter between two individuals. The only therapeutic factor is the availability of the therapist towards his own emotions and those of his interlocutor, his degree of authenticity as well as his internal coherence. According to Rogers, a therapeutic discussion corresponds to:

“Two people face to face, in a case where it is unimportant to define that one is the therapist and the other the patient. It is not the professional belonging that makes a therapist, nor the theoretical and technical knowledge, but the desire and capacity to help.”

The rogerian therapy is also a process of research, that of discovery of oneself and of others. Firstly, it is an encounter that tends towards affective engagement, refusal of protective compartmentalisation, responsibility and love. The non-directivity of the therapist recommended by Rogers isn’t in the absence of desire to influence, but in the availability to be influenced in return, in other words to the process of mutual influence. The different techniques described (reformulation-reflection, reformulation as a reverse rapport, reformulation clarification, confrontation, etc.) as well as the recommended attitudes (empathy, authenticity and sense of the immediate) only make sense through the intention that animates them.

According to Carl Rogers, developer of the idea, the definition of empathy corresponds to: *"an intuitive presence for others in which we are more centred on ourselves but for the other, totally attentive to our their feelings, while still deeply being ourselves without defensive tension."* One must enter the universe of emotions of the interlocutor, while staying oneself. This implies :

- welcoming the other, accepting him as he is, thinks he is and presents himself as ;
- trying to understand who he is, how he lives.

The attitude of empathic understanding consists in:

⇨ understanding internally what the other is going through

⇨ communicating what we have understood

⇨ offer a welcoming and solid presence instead of speech

Let's remind that understanding doesn't mean approve. It is listening to hear precisely, by being oriented towards the other as a subject, and centred on what the person has experiences, instead of the facts that the person expresses. In this sense, empathy is not a form of sympathy in which we identify ourselves to the other, which would prevent us from helping the other. It isn't either a form of benevolent neutrality where the subject would be treated like a case instead of a person, but *"… consists in perceiving the internal reference frame of another person with exactitude and with the emotional components and the meanings that are attached to them, as if we were the other person, but without losing the "as if" condition… if this "as if" quality is lost, it is then an identification and not empathy".*

Empathy, this capacity to understand how the other feels, discovers and invents his interior or exterior worlds, we all practice it. The problem is that often we make mistakes in our estimates. We suppose that what happens in the head of others is identical to what happens in ours. We forget that we are different. Making use of empathy, means recognising these differences and take advantage of them to grow. To reach it, we cannot spare a certain de-centring and continuous verification concerning what we think we understand. The reformulation techniques are a pertinent tool in this complex task.

Reformulation – reflection :

Where one of the interlocutors is seized again with equivalent words, without adding anything to the content and without judgment or interpretation of any kind (as best as possible).

Reformulation as a reverse rapport:

Where one must take out the latent content of a speech in order to send the subject back to himself as well as to his word.

Reformulation – clarification:

Which helps the subject to keep the essential parts of his speech. It works with the part of the speech that seems central, or reveals the "leitmotiv" of the interlocutor.

Confrontation:

It corresponds to a specific demand made to the interlocutor in order to examine certain aspects of his behaviour that are in discordance or in contradiction with what he has said or done. It must take in account the verbal, para-verbal and non-verbal aspects of communication. It can be of the following different types:

- Informative : describing the visible behaviour of the other person
- Interpretative : expressing the emotions and the thoughts concerning the behaviour and can understand the hypotheses on its meaning

An efficient confrontation relies on six elements at least:

1. the use of personal pronouns like I, my and individual assertions ;
2. the use of phrases and assertions through which the treating person expresses what he feels facing his interlocutor ;
3. the descriptions of the visible behaviour of the person (analysis) ;
4. the description of the personal feelings by specifying the name of these emotions ;
5. the use of responses aimed at the understanding of the behaviour such as paraphrases or verification of perceptions ;
6. the use of constructive techniques of retroaction.

The authenticity:

It corresponds to the ability to be true and to express with honesty, when the treating person deems it pertinent to do so, the emotions, feelings, images, fantasies, thoughts and hypotheses.

The sense of the immediate:

It is the quality allowing the treating person to react to the elements that occur between him and the treated in the relationship here and now. Intimately linked with confrontation, we go from the idea according to which the events of a relationship between a person and his environment have a very strong probability to find themselves in our relation with the person. In this sense, bringing back the problem between the person and us, allows a clear enrichment of the understanding for the two interlocutors. Authenticity keeps all its importance here, for it is useless to think about leading the subject to a contact with his/her emotions and clarifying his/her thoughts if we do not do the same with him/her.

These elements are inspired by psychoanalysis, psychology and humanist approaches. They offer a good framework to orient the intervening person in his accompanying task. However, the work with victims requires a particular adaptation that we will talk about now.

No intervention that would take the power from the person can participate in this recovery; even if would seem to be in the immediate interest of the person. In certain exceptional circumstances, when the person has abdicated all responsibility for his/her handling, or when he/she seems to represent a risk to himself/herself or for others, a quick intervention is necessary with or without his/her consent. However, the person should still be consulted, and be offered the most possible choices, as long as it doesn't put his/her security at risk. Moreover, the victim has seen their trust severely altered. He/she must imperatively find an ally in the intervening person. The risk of the person becoming dependent of the intervening person is so high that the latter must show himself/herself extremely attentive to seem disinterested and neutral:

- **disinterested,** in the sense that he/she must refrain from using his/her power to satisfy personal needs and where
- **neutral** means that he must not take part in the internal conflicts of the person nor try to dictate his/her decisions.

However, the development of a relationship of trust requires that the intervening person or the therapist explicitly assume a position of solidarity towards the victim. At first, this means that he must strictly recognise a status of victim for the person. This doesn't mean that the person can't have committed any errors; it only implies the understanding of the fundamental injustice of the traumatic experience and the need for restoration of a certain sense of justice.

Recognising the status of victim of the person is a necessary step towards the creation of a relationship of trust, it's an answer to the intense need to be acknowledged and probably is the only way to beat the feeling of guilt deeply implanted in the traumatised person. At the same time, it is an extremely risky position at medium or short term concerning the door it opens towards coalition, over-simplification, and dependence creating as well as other relationship based traps.

But the insistent question, if one must acknowledge the status of victim, concerns how not to enter a triangulation (victim, persecutor, saviour). How not to be sucked in by the emotional turmoil ? The triangle of Karpann (or dramatic triangle) describes this type of relationship (the reader will find a description of it in the "occupational hazard" chapter). The "tenants" of the Transactional Analysis suggest that it isn't possible to get out of it, that the harm would reside in the act of inhabiting only one of the states. According to me, there is much to bet that it is impossible not to go, at some point, from saviour to persecutor in the eyes of someone, so evident it is that we cannot prevent from frustrating each and everyone. As we have clearly seen in these last two chapters, helping someone can participate in creating dependence. Which cannot be helpful !?

One must consider the multiple games produced by our own defence mechanisms. These defence mechanisms are activated to try and manage our internal conflicts as well as the emotional burden (anger, rage, horror, hate, sadness, helplessness…) induced by the situation and the feelings perceived by the people for whom we intervene. The multiple games that these mechanisms produce will be of the field of division, idealisation, demonising and the perverted use of these situations to manage our own impulses or even repeat a situation as we have seen in the article of Maurice Hurni and Giovanna Stoll (1997).

So, if I cannot prevent from being seen as a persecutor, what can I do? A few seconds of reflexion and the answer is obvious: avoid being victim or saviour. Indeed, if I wish to interrupt, or at least not participate in a dramatic triangle, I must work on what I have a potential effect. In this sense, I can try not to be a victim and avoid maintaining the triangle at any price while assuming the role of saviour, as delicious as it may be.

We should however accept that it is not easy to avoid being victim. We must admit that the other or the elements are often more powerful than us. However, if we cannot prevent from being, at a given time, victim, we must make sure not to develop a victim identity. For this, I suggest 5 steps, "the steps towards de-victimisation" (the first having been added by Diane Lauzier) which are:

⇨ **Re-establish the facts,** is being able to develop a reflexion on the situation and take the whole of our responsibilities. We distinguish responsibility from guilt. This step is fundamental, it allows the passage to the others, but staying stuck on it would imply becoming an "enlightened victim" or worse, someone eaten by guilt.

⇨ **Be able to say no,** is affirming oneself, showing our interlocutor that we are not an object at his disposal. Again, this step is fundamental, however staying stuck on it too long would make us a "passive-aggressive condition", spending our time rejecting all the propositions, refusing any collaboration.

⇨ **Name what I want** is the logical next step of the process. Indeed, one must not just rise against what we do not want, one must also be able to express what he wants. The point is to name our objectives. Naturally, stopping at this step would make us a persecutor, as we would spend our time rejecting the objectives of our interlocutor to impose our own.

⇨ **Accepting to negotiate:** to enter a real interdependent relationship, the wish to negotiate is necessary. It implies accepting to listen to the other while respecting ourselves, be ready for a compromise, but certainly not to compromise ourselves.

⇨ **Accepting the separation:** to show that we are indispensable as it is evident that it isn't always possible to negotiate. If we want to ride in the same car, we must go in the same direction. The objectives of each are not always compatible; must we not resign ourselves to change companions ?

Having considered everything, if we wish to stick to this process in order to avoid developing a durable identity of victim, there is every chance that we won't slip into the role of saviour. Indeed, the person claims there needs and desires, names their objectives, accepts their choices, in four words, he/she takes their responsibilities. **Not only does he/she take all his/her responsibilities, but also, only his/her responsibilities**, allowing the other protagonists to do the same. It is probably in the pertinent distribution of responsibilities that there is a chance to come out of the dramatic triangle.

7. PRACTICING PSYCHOLOGICAL DEBRIEFING WITH CHILDREN
by Dr Christophe GRANDJEAN

7.1. Introduction

Society, after the scientific community now recognises that children and adolescents are exposed to a wide variety of possibly traumatising experiences, resulting in severe stress reactions and other psychopathology for a large proportion of them. According to William Yule (R. Orner & U. Schnyder, 2003, *Reconstructing early intervention after trauma*, Oxford University Press, Oxford, UK) we recognise this distress as a crushing motivator to act : " *Early intervention strategies may serve a variety of needs simultaneously. These include the need for people to provide assistance and to show concern, the need of survivors to talk about and understand what has happened and to gain control, and the need of those not directly affected to overcome feelings of helplessness, guilt at having survived and to experience and master vicariously the traumatic encounter. As far as children are concerned there is also the need to reunite the children with their parents or other family members. Thus, there is also an imperative to do something and, in this increasingly litigious society, to be seen to be doing something. Over a very short period, survivors of disasters have come to expect that some form of counselling will be offered for them*." Still, the question concerning the form, the time and the duration of the intervention remain open. Benefits and risks shall be carefully considered and establishing appropriate measuring and evaluation instruments is still a challenge.

Our experience in the field tends to show the utility of early intervention with children after critical incidents. We found that this early intervention could take the form of the now controversial debriefing, providing there are some adaptations linked to the specificity of this population. Modifications concern the specific expression of traumatic suffering in children, the way the professional speaks to children and vice versa, and, last but not least, the care that has to be taken of the adults in charge of these children (parents, teachers or other caretakers).

However, we prone a certain prudence in the use of this method. For instance, we do not recommend its use in cases of war trauma, sexual abuse, child neglect and mishandling nor in log-lasting situations resulting in multiple and/or chronic traumatic stress. Indeed, these conditions not only impair the development of many cerebral structures and functions, but also produce deep personality changes in children and adolescents. Thus a short term intervention seems to be rather inappropriate considering the multiple problems associated with such situations. The Multiple Stress Debriefing Model could possibly be used to assist children facing brutal and major changes in their lives with multiple consequences for example after revelation of violence and sexual abuse. Hospitalisation, medical examination, legal interviews, rupture with significant family members and so on constitute potential sources of secondary traumatism. The target would not e the chronic stressing condition, but these sources of secondary traumatism. We will not develop this topic, limiting ourselves to taking into account the memory of a unique and sudden event for which the individual cannot possibly be prepared.

7.2. Psychotrauma in Children

Globally considered, children show a large variety of reactions including acute stress and PTSD after a critical incident, with many differences according to their physical, affective and cognitive development levels in comparison to adults. If it is possible to find children with a typical and complete PTSD according to the DSM-IV (but not with children younger than 6 years old), many symptoms of only a part of the different symptom clusters usually appear. This means that many children who experienced a really critical incident could be severely disturbed and some of them could develop long-term complications without being recognised as patients suffering from a chronic PTSD. It is also possible to meet children that fulfil DSM-IV criteria for PTSD but without being directly or indirectly exposed to a critical incident nor encountering any loss in relation with the event. This has been acknowledged with children who have watched for many hours and sometimes all day long TV loop-reports of the disaster of 11th September in Manhattan. It is also well known that children may develop some typical post-traumatic stress symptoms by proxy, as an outward sign of a relative's suffering after a critical incident. PTSD might be found in children without a history of a critical incident as defined in the DSM-IV, but as a reminder of a common life-event that would not be considered as traumatic. Lack of reaction during the traumatic exposure, delayed post-traumatic stress symptoms, loss of acquired developmental skills and separation anxiety are very commonly found among traumatised children, whereas flash-back, the most typical symptom of PTSD in adults, is difficult to spot.

In addition, it is now acknowledged that DSM-IV criteria are not so useful when dealing with traumatised children, despite the fact that many self assessment scales show good reliability in detecting PTSD. We consider that the DSM-IV criteria modified by Scheeringa and the Zero-To-Three Classification are much closer to the clinical reality of PTSD among children. The Zero-to-Three Classification may also be precious to deal with children between 3 and 6 years old. These classifications include many developmental items that have to be considered with small children often showing a temporary or a long-term loss of abilities. They also give better specifications of children's re-enactments in playing, drawing or in somatic disturbances that may appear before the children have developed a full verbal level of expressing what they feel. For details, see Table I.

There is no difference between the reactions to traumatic events of adolescents and adults. However we have to remember that reactions to one recent event may hide chronic stress and repetitive traumas or previous events not yet overcome, that are much more frequent than ideally expected in adults during childhood. Epidemiological studies have showed that a high percentage of young people fulfil criteria of having experienced traumatic events (thus needing a revision of an idealised happy childhood). Long term follow-up of severely traumatized adolescents shows that they often develop conduct disorders, drug addiction, and may attempt suicide. In addition with the typical adolescent pattern of relationship with the adults, critical incidents may harm the trust that children and adolescents have in adult's life model, resulting in a deep pessimistic frame of mind. Younger, traumatized children may show the same in another way, for example expecting they will never reach the adult's age.

To complete this chapter from a clinical point of view, we want to underline the fact that traumatic events and chronic stress often result in symptoms and diagnosis other than PTSD: Mood disorders, generalised anxiety and separation anxiety disorders, personality disorders, attention deficit/hyperactivity and disruptive disorders, mental retardation, pervasive developmental disorders... Although not pathological, the mourning process has a lot of overlapping symptoms with acute stress or PTSD.

7.3. Working with Children and Adolescents

We have to remember that children do not have the same language and verbal ability as adults. The younger they are, the more they express their suffering through psycho-somatic disorders, for example with sleep and food disturbances. In contrast, babies and toddlers show a very high level of sensitivity to a lot of infra-verbal messages and in particular to how their parents feel. For this very reason, we think that small children should be associated in a family-wide early intervention also involving the more elderly members. If they cannot really understand the professional's words, they surely know that something like an important ritual is happening. Later, one can remember that all, young or old were there to close the event. A two-year-old girl told us something about her nightmares. Of course, we were not able to understand anything she said, but her mother acted as a translator, so we knew that she understood that her family was there to speak of their fears. This means that as soon as they are able to speak, they can actively participate. They will perhaps not understand much about PTSD, but they will surely feel better when they will hear their relatives expressing their pain and feeling their relief at the end of the process.

Before 6 years old, children are not yet objective about their environment and what happens. The professional has to deal here with the child's illusion that what disappears can come again when he wishes. It is the same concerning the representation of death, something that looks like sleep with probable awakening after some time. Their highly subjective, self-centred knowledge of the world also means that children may have very heavy guilt feelings when somebody dies and when they note how their relatives are touched, even though these children have not participated at all in this death. "I was bad and he went..." is a current theory that may be complicated to resolve when the child has had ambivalent feelings for the person victim of a traffic accident. We believe that professionals should use the most simple words to give the most objective summary of the event, without minimising or hiding anything (that could harm the trust the children have in adults): usually, children know what happened and are seeking confirmation of what they have heard and believed, sometimes looking for an adult able to speak about the event without breaking down.

With children of this age, symbolic or metaphoric expressions like "he is gone" that could mean "he will be back" should be carefully avoided when speaking about a dead person. In the same manner, it is better to explain the symptoms that lead to an understanding of feelings, for example difficulties to breath rather than oppression, the former being the word proposed by the professional to sum up what he understood. The same is to be done with mentally-handicapped or psychotic children, who often understand metaphoric expressions only in a literal sense.

Generally the professional has to enumerate and describe the different symptoms because children are often not able to report by themselves what they feel. But they will recognise as true or not what is mentioned, or, if they do not understand, the specialist has to explain what he means. It is possible that some children be induced to adopt one or another of the practitioner's words to describe their misfortune. As we are not legal interviewers, we do not think that this influence is harmful. At least, these children will grow and learn and slowly find the most adequate word but at the beginning, they should have some ways to express their discomfort. Handicapped or mentally-ill children are the most exposed to a lack of words to express their emotions, so we think that for this population in particular this attitude of proposing words is very important. We also think that any traumatic event can lead to a developmental regression of the cognitive and language level, so it really makes sense to speak in the most simple manner to be understood and to continually check the mutual comprehension. This is of course evident with children suffering from language disabilities, making the presence of a speech therapist or a specialised teacher useful.

As children lack words and considering their natural resources, it makes sense to use what they spontaneously do, such as playing with toys and dolls, making models and drawing. That could help to recall and reconstruct the event. Drawing is an old method of debriefing with children who have gone through a critical incident (for example drawing a good record of the passed time or what was before, during and after the disaster, or what they hope for the future, or what would help them to face it). Children may just be able to draw on demand and suddenly attain a level of excitement related to the event, making at least only compulsive crumpled scrawls that have no more meaning and value than a re-enactment.

Setting a group of highly excited children in an individual drawing activity can contribute to calm the atmosphere when verbal communication is no longer possible it is also advisable to take a break outdoors for a few minutes (we must keep in mind the limited attention capacity in children, exhaustion been, as well, source of agitation), and if it is still not possible to continue, it is better to defer the session. Exposure and comments about the event, the feelings and the future with the drawings made during the session is another good way for the children to express what they have gone through. With toys, the counsellor has to remember that if he allows the children to play with them, it could lead to the same re-enactment. Sometimes it is useful for the professional to understand what children have experienced (and are still, repetitively playing), but, at least, the aim is to understand and to give sense to what happened and not to experience it again.

At this point we would like to mention that it is important that children must be prepared to face the facts. A funeral ceremony, a visit to the intensive care unit may be a source of secondary traumatism when they see the adults they trust so strongly moved. When children are well prepared, they can assume an active participation to adult rituals. The specialist should encourage them to use their own creativity, making them active in their own mourning course with drawings, poems, songs...

Meeting adolescents requires one to be conscious that many critical incidents (particularly those involving adult failure or acts of human violence) are susceptible to severely impair the trust in any adults, including in the most honest professional. On the other hand, peer group influence and solidarity is one resource on which the counsellor can count. But this can also bring to the session some adolescents who are not able to face the event again, thus making sense not to try to break through their mutism or to interpret their hostility. This kind of intrusion is a sure way to induce a secondary traumatism with a higher probability of causing a PTSD... We know that suicide may be epidemic in high schools and colleges or lead some individuals to life-threatening behaviour. Adults sometimes have difficulties to speak about these topics with the younger generation. We think that debriefing or other verbal techniques should be used with these risk groups after such events to open discussion and, perhaps, to relieve an overriding sense of guilt and loneliness after a suicide. In this way we can hope that a second suicide attempt will not happen.

7.4. Support for Parents

It is now well known that children overcome a traumatism in a very close way to how their relatives react. This high sensitivity is a consequence of their dependence on their caretakers. The very young child will react more to the perturbation of his mother than to the critical incident itself. Making a debriefing with parents who are anxious about the critical incident's consequences on their babies and toddlers means helping them first to recognise and accept their own symptoms following the event. It is evident that it is not so simple to do. We have to consider all the time that children as primary victims of an event lead their parents to a status of tertiary victims and reciprocally. In consequence it is possible to find a lot of avoidance mechanisms among adults that disturb the screening of PTSD among children.

Furthermore, children may show no reaction following the event, perhaps as a protective mechanism which works as long as their parents are unable to recover a holding capability including the possibility of elaborating the traumatism. PTSD then occurs in a very insidious way with children of falsely reassuring (but really avoiding) parents.

On the other hand, any critical incident affecting children leads to a peak of emotions among adults that is boosted through the media and all identification mechanisms working from parents to parents. An objective information is a first psychological aid to bring down the panic wave among adults. It is now possible to find on the Internet many of useful sites helping both adults and children to live with risk and to recognize the possible symptoms of acute stress or of PTSD after a critical incident (for example http://www.aacap.org/publications/). These sites may also help adults to avoid inadequate reactions to some children's symptoms like repetitive and morbid games considered pernicious. At least, these "symbolic" games are normal for a certain time and are a spontaneous, healthy way for children to overcome an event by trying to understand what happened and recover some virtual control over it. These games are to be considered as pathological only when they remain unchanged in frequency and content during many weeks.

The counsellor should first help adults to face the event, its consequences and their own reactions, using information, defusing and debriefing methods. This should bring some calm back and then make it possible to study what is necessary for the children. That implies the necessity of objective information (that is usually dramatised and partial or hiding the essential) like adults and then defusing with their current caretakers, with or without help of specialists. In most cases, this will be sufficient to recover a normal way of life. We use formal debriefing in situations where children or the adults around them have changed after the event: death of a school friend, disappearance of a father for example.

In most cases, we prefer to include some familiar adults in the debriefing session with children. The contact with the group is thus easier and, if one child cannot stand the procedure, an adult can take him out and stay with him until the session ends. As indicated above, adults have to anticipate what will or might happen during the session, with a clear role definition between them about the responsibility and the leadership of the group, respectively the procedure. The same is to be done with single families: parents should keep their responsibility for their own children as long as possible. We usually suggest two debriefing sessions should be done, the second one taking place some weeks later. A follow-up setting is useful, but could be reduced to a phone call between the specialist and the caretakers. During the call, the professional can evaluate the need for an other session with all or part of the group to sustain the elaboration of the event.

Finally, psychological debriefing with children shows many advantages. First, it may help adults to find the right words to explain to children what happened, and thus reopens ways and possibilities of discussion about the event. Secondly, it helps children to find the words in relation to their symptoms and pain. Thirdly, it contributes to preparing them to face following events. These points are preliminary to the symbolisation of the trauma. At least, it should be considered as a way to welcome and to support children and their relatives after a traumatic event. In that way, the formal procedure is essentially a helpful guideline for the counsellor himself. Beside this social and pedagogic mission, meeting children in difficult conditions following a dramatic event implies a very good knowledge of the children's developmental stages and of their specific manifestations of acute and post-traumatic disorders.

To conclude this chapter, let us express our respect for the psycho-social work done on the Pier 94 in Manhattan after the WTC disaster. Psychologists of Columbia University assisted traumatised and bereaved children and their families in a very open and respectful way. They have also shown us the wide range of children's reactions to trauma.

DSM-IV: Diagnostic Criteria for F43.1 [309.81] Posttraumatic Stress Disorder	Scheeringa's PTSD Alternative Criteria for Infancy and Early Childhood	ZERO-TO-THREE: Diagnostic Criteria for 100.- Traumatic Stress Disorder
Issued by: American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, 1994, Washington DC	*From:* Scheeringa MS, Zeanah CH, Drell MJ, Larrieu JA: Two approaches to the diagnosis of posttraumatic stress disorder in infancy and early childhood. J Am Acad Child Adolesc Psychiatry 1995 Feb ; 34 (2) : 191-200	*Modified from:* ZERO TO THREE / National Centre for Infants, Toddlers and Families: Diagnostic Classification: 0-3, 1994, Washington DC
A. The person has been exposed to a traumatic event in which both of the following were present: 1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others 2) the person's response involved intense fear, helplessness, or horror. *Note: In children, this may be expressed by disorganised or agitated behaviour*	A. 1) same 2) deleted	Traumatic stress disorder describes symptoms which may be shown by children who have experienced a single event, a series of connected traumatic events, or chronic, enduring stress. If there has been such condition and the child is showing symptoms as described below, Traumatic Stress Disorder has precedence over any other primary diagnosis.
B. The traumatic event is persistently reexperienced in one (or more) of the following ways: *1)* recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. *Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.* 2) recurrent distressing dreams of the event. *Note: In children, there may be frightening dreams without recognizable content.* 3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). *Note: In young children, trauma-specific re-enactment may occur.* 4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.	B. Reexperiencing. One item needed: 3) posttraumatic play: compulsively repetitive, represents part of the trauma, fails to relieve anxiety and is less elaborate and imaginative than usual play 4) play reenactment: represents part of the trauma but lacks the monotonous repetition and other characteristics of posttraumatic play 5) recurrent recollections of the traumatic event other than what is revealed in play, and which is not necessarily distressing 6) nightmares: may have obvious links to the trauma or be of increased frequency with unknown content 7) episodes with objective features of a flashback or dissociation 8) distress at exposure to reminders of the event	1. Re-experiencing of the traumatic event as indicated by the following: c) posttraumatic play, meaning compulsive, less elaborated play without pleasure, showing parts of the event d) repetitive questions or comments about the event, with or without perceptible anxiety e) recurrent nightmares, especially linked to the event f) distress at exposure to reminder of the event g) Re-enactment dissociated from the present context and without any intent, revealing some aspects of the trauma, equivalent to a flashback

DSM-IV: (continued) Diagnostic Criteria for F43.1 [309.81] Posttraumatic Stress Disorder	Scheeringa's PTSD Alternative Criteria for Infancy and Early Childhood (continued)	ZERO-TO-THREE: (continued) Diagnostic Criteria for 100.- Traumatic Stress Disorder
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following: 1) efforts to avoid thoughts, feelings, or conversations associated with the trauma 2) efforts to avoid activities, places, or people that arouse recollections of the trauma 3) inability to recall an important aspect of the trauma 4) markedly diminished interest or participation in significant activities 5) feeling of detachment or estrangement from others 6) restricted range of affect (e.g., unable to have loving feelings) 7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)	C. Numbing of responsiveness. One item needed: 1) constriction of play. Child may have constriction of play and still have posttraumatic play or play re-enactment. 2) socially more withdrawn 3) restricted range of affect 4) loss of acquired developmental skills, especially language regression and loss of toilet training	2. Numbing of responsiveness or interference with the developmental course. One item needed: a) enhanced social withdrawal b) restricted range of emotion c) temporary loss of acquired developmental skills (language, toilet training, …) d) diminution or restriction of play
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following: 8) difficulty falling or staying asleep 9) irritability or outbursts of anger 10) difficulty concentrating 11) hypervigilance 12) exaggerated startle response	D. Increased arousal. One item needed: 5) night terrors 6) difficulty going to sleep which is not related to being afraid of having nightmares or fear of the dark 7) night-waking not related to nightmares or night terrors 8) Decreased concentration: marked decrease in concentration or attention span compared to before the trauma 9) hypervigilance 10) exaggerated startle response	3. Increased arousal. One item needed: a) night terrors b) refusal to go to bed, difficulty to get asleep c) night waking not related to nightmares d) significant impairment of attention e) hypervigilance f) exaggerated startle response
E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than 1 month	E. New fears and aggression. One item needed: 11) new aggression 12) new separation anxiety 13) fear of toileting alone 14) fear of the dark 15) any other new fears or things of situation not obviously related to the trauma	4. Symptoms not present before the traumatic event. One item needed: a) aggression against peers, adults or animals b) separation anxiety c) fear of toileting alone d) fear of the dark e) any other new fear f) defeatism or manipulative or masochistic provocative behaviour g) inadequate sexualised and aggressive behaviour considering the child's age h) somatic symptoms, conduct re-enactment, somatic pain or painful posture
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if: - Acute: if duration of symptoms is less than 3 months - Chronic: if duration of symptoms 3 months or more Specify if: With delayed onset: if onset of symptoms is at least 6 months after the stressor	F. Duration of disturbance greater than 1 month	

BIBLIOGRAPHY

1. Crocq L. Perspectives historiques sur le trauma. In : De Clercq M, Lebigot F, éditeurs. Les traumatismes psychiques. Masson, Paris, 2001, 36-53.

2. CIM-10/ICD-10. Classification internationale des maladies. 10ème révision. ChapitreV(F). Troubles mentaux et troubles du comportement. Descriptions cliniques et directives pour le diagnostic. Organisation mondiale de la Santé. Traduction de l'anglais par Pull CB. Masson, Paris, 1993.

3. DSM-III Manuel diagnostic et statistique des troubles mentaux. American Psychiatric Association, version internationale, Washington DC, 1987; traduction française par Guelfin JD et al., Masson, Paris, 1989.

4. Mouren-Simeoni MC. Actualité du syndrome de stress post-traumatique chez l'enfant. Annales médico-psychologiques, 1994; 152, 10: 685-688.

5. Vila G, Bertrand C. Etats de stress post-traumatique de l'enfant et de l'adolescent: particularités cliniques. Stress et Trauma, 2001; 1 (3): 161-168.

6. Papazian B. Traumatisme psychique en cas de catastrophes. Psychiatrie de l'enfant, 1992; 35 (1): 273-314.

7. Minkowski A et al. Le stress et ses conséquences psychiques chez les enfants exposés à la guerre et aux catastrophes naturelles. Devenir, 1993; 5 (1): 55-73.

8. Schwarzwald J et al. Stress reactions of school-age children to the bombardment by SCUD missiles. J abnor Psychol 1993 Aug: 102 (3): 404-410.

9. Schwarzwald J et al. Stress reactions of school-age children to the bombardment by SCUD missiles: a 1-year follow-up. J Trauma Stress 1994 Oct: 7 (4): 657-667 [abstracts])

10. Laor N, Wolmer l, Cohen DJ. Mothers' functioning and children's symptoms 5 years after a SCUD missile attack. Am J Psychiatry 2001 Jul; 158 (7): 1020-1026.

11. Di Gallo A, Barton J, Parry-Jones WL. Road trafic accidents: Early psychological consequences in children and adolescents. British Journal of Psychiatry, 1997; 170: 358-362.

12. Winston FK et al. Acute stress disorder symptoms in children and their parents after pediatric trafic injury. Pediatrics, 2002 Jun; 109 (6): e90.

13. Vila G et al. A study of posttraumatic disorders in children who experienced an industrial disaster in the Briey region. European Journal of Child and Adolescent Psychiatry, 2001 Mar; 10 (1): 10-18.

14. Vila G, Porche LM, Mouren-Simeoni MC. An 18-months longitudinal study of post-traumatic disorders in children who were taken hostages in their school. Psychosomatic Medicine, 1999; 61: 746-754.

15. Scheeringa MS et al. Two approaches to the diagnosis of post-traumatic stress disorders in infancy and early childhood. Journal of the American Academy of Child and Adolescent Psychiatry, 1995; 34: 191-200.

16. Dethieux JB, Raynaud JP, Abadie I. Pathologies limites de l'enfant et traumatismes: quels liens? Stress et Trauma, 2001; 1 (3): 169-174.

17. Grappe M. Deuil et traumatisme chez l'enfant et l'adolescent. Stress et Trauma, 2001; 1 (5): 291-296.

18. Grossman JA et al. Child bereavement after paternal suicide. Journal of Child and Adolescent Psychiatric Nursing, 1995 Apr-Jun; 8 (2): 5-17.

19. DSM-IV Manuel diagnostique et statistique des troubles mentaux. American Psychiatric Association, version internationale, Washington DC, 1995; traduction française par Guelfin JD et al., Masson, Paris, 1996.

20. Muris P et al. Screening for trauma in children and adolescents: the validity of the Traumatic Stress Disorder Scale of the screen for child anxiety related emotional disorders. Clinical Child Psychology, 2000; 29, (3): 406-413.

21."Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. Journal of The American Academy of Child and Adolescent Psychiatry, 1998; 37 (10, supplement): 4s-26s.

22. Cohen JA. Summary of Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. Journal of The American Academy of Child and Adolescent Psychiatry 1998; 37 (9): 997-1001.

23. Harpreet S et al. PTSD and TV viewing of World Trade Center. Journal of The American Academy of Child and Adolescent Psychiatry 2002; 41: 494-495.

24. Tierney JA. Post-traumatic stress disorder in children: controversies and anresolved issues. Journal of Child and Adolescent Psychiatric Nursing, 2000 Oct-Dec; 13 (4): 147-158.

25. Carrion VG, Weems CF, Ray RD, Reiss AL. Toward an empirical definition of pediatric PTSD: the phenomenology of PTSD symptoms in Youth. J Am Acad Child Adolesc Psychiatry, 2002 Febr; 41 (2): 166-173.

26. Silva RR, Alpert M, Munoz DM, Singh S, Matzner F, Dummit S. Stress and vulnerability to posttraumatic stress disorder in children and adolescent. Am J Psychiatry, 2000 August; 157: 1229-1235.

27. Zero to Three, National Center for Infants, Toddlers and Families, Washington DC, 1994, traduction française Ed. Médecine et Hygiène, Genève, 1998.

28. Scheeringa MS, Peebles CD, Cook CA, Zeanah CH. Toward establishing procedural, criterion and discriminant validity for PTSD in early childhood. J Am Acad Child Adolesc Psychiatry 2001 Jan; 40 (1): 52-60.

29. Carrion VG, Weems CF, Eiez S, Patwardhan A, Brown W, Ray RD, Reiss AL. Attenuation of frontal asymmetry in pediatric posttraumatic disorder. Biol Psychiatry 2001 Dec 15; 50 (12): 943-951.

30. De Bellis MD, Keshavan MS, Frustaci K, Shifflet H, Iyengr S, Beers SR, Hall J. Superior temporal gyrus volumes in maltreated children and adolescents with PTSD. Biol Psychiatry, 2002 Apr1; 51 (7): 544-552.

31. De Bellis MD, Hall J, Boring AM, Frustaci K, Moritz G. A pilot longitudinal study of hippocampal volumes in pediatric maltreqatment-related posttraumatic stress disorder. Biol Psychiatry, 2001 Aug 15; 50 (4): 305-309.

32. Rose S, Bisson J, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD) (Cochrane Review). In: The Cochrane Library, Issue 1, 2003. Oxford: Update Software.

33. Pfefferbaum B. Posttraumatic stress disorder in children. A review of the past 10 years. J Am Acad Child Adolesc Psychiatry 1997; 36: 1503-1511.

34. Vila G, Porche LM, Mouren-Simeoni MC. L'enfant victime d'agression. Etat de stress post-traumatique chez l'enfant et l'adolescent. Masson, Paris, 1999.

35. Leuenberger JF. Sensibilisation au débriefing dans le contexte scolaire. Rev Med Suisse Romande. 1997; 117 (5): 413-418.

36. Herzig L, Muller C. Debriefing dans un cadre scolaire par l'équipe Jeunesse et Santé. Gestion des conséquences d'un assassinat dans une classe d'apprentis. Rev Med Suisse Romande. 1997; 117 (1): 55-59.

37. Klauser-Reucker C. Erfahrungen einer Allgemeinärztin mit Debriefing. In: Perren-Klingler G Ed. resp. Debriefing. Erste Hilfe durch das Wort. Hintergründe und Praxisbeispiele. Haupt, Bern, 2000. Trad. franç.: Maux en mots. Débriefing: modèles et pratique. Viège (Suisse), Institut Psychotrauma, sept. 2002, 145-157.

38. Clément V. Debriefing in der Schule: Wann, wie, von wem, warum. In: Perren-Klingler G Ed. resp. Debriefing. Erste Hilfe durch das Wort. Hintergründe und Praxisbeispiele. Haupt, Bern, 2000. Trad. franç.: Maux en mots. Débriefing: modèles et pratique. Viège (Suisse), Institut Psychotrauma, sept. 2002, 173-186.

39. Bailly L. Syndromes psycho-traumatiques chez l'enfant. In : De Clercq M, Lebigot F, éditeurs. Les traumatismes psychiques. Masson, Paris, 2001, 137-147.

40. Hanus M. Le deuil chez l'enfant. In : Lebovici S, Diatkine R, Soulé M. Nouveau traité de psychiatrie de l'enfant et de l'adolescent, 2ème édition. PUF, Paris, 1995, 1463-1476.

8. SPIRITUAL SUPPORT

8.1. Traumatic shock and spiritual support (Maurice Gardiol & Cosette Odier)

He who does not question himself does not live a human life

Platon (Apologie de Socrate I,28)

In the last few years, numerous contacts have been established between Geneva's religious communities and the reception cell for traumatized people. The objective has been to integrate the possibility of spiritual support into the psychosocial support which is already provided. Several sessions in training and dialogue have led us to the following reflections.

Rethinking the spiritual and the religious

The more global approaches which integrate the human person have allowed us to partly transcend the rationalism and positive scientism which led to a divided understanding of the individual during the 20th century. This view was reinforced, on a religious level, because of the neo-platonic concept opposing soul and body. This point of view caused some to scorn the "soma" (body) while others considered the "anima" (soul) as an irrational and archaic concept which scientific thought, enlightened by the lights of reason, must denounce.

The resistance and persistence of religious feeling, outside the traditional institutions which were to manage and even promote it, the highlighting of psycho-somatic disorders, as well as the confrontation with other cultures through the miscegenation that is common in modern societies, have lead us to correct our outlook on humanness and to rediscover the complexity of each individual existence, and the permanent reactions of which it is constituted.

"To exist is more than life" says the contemporary philosopher relying on the thoughts of Kierkegaard and Paul Ricoeur. Thus he can write: "To exist is not living reduced to its function and which, consequently, could be explained by a group of causes and effects. To exist is living in quest of meaning, and consequently it is situated in time, thus aware of its finiteness. To say that it is in quest of meaning, is to claim that it is inhabited by freedom and that consequently it cannot be reduced to what we can know or say of it through explanations based on the concept of causality…"

Thus, it is necessary to distinguish the spiritual dimension from the religious dimension. In our western culture particularly, many existential questions are asked in spiritual terms by those who are not attached to any religious community. Even though we may not claim their thought processes, we are aware that our questions are close to those which are suggested, in religious terms, by those who are part of a religious community.

Traumatic shock and spirituality

Certain forms of religiosity may seem to fuel magical beliefs, but while avoiding behaviours or various reassuring superstitions, we must recognise that faith is a resource for many people. It allows them to nourish spirituality and a communion "connecting" to transcendence, where every individual history is part of a wider project, linked to the history and culture of the community.

On a deeper level, it gives meaning and orientation to their existence. The French verb "s'orienter" etymologically means "to turn to the Orient", which symbolically means: "to turn to a place where the meaning of all beings comes from". We are accustomed to saying that in traumatic shock, we are disorientated. Not only in time and space, but also in relation to our usual reference points. This disorientation can be found in popular expressions like:

"Oh God, what have I done to you?"
"Why is this happening to me?", etc.

They show a feeling of injustice and abandonment, revealing an unbearable confrontation with the absurd, the tragedy of life and the awareness of a fragility which is ignored or refused. This cry from a deep woundedness may, in certain situations, become a call for revenge, a desire to destroy others or oneself. But crying out loud means you're alive! Certain ancient traditions such as the Psalms or the Book of Job show the importance of "exteriorising" our anger, even against God, and of being authorised to say so in terms that would be otherwise considered excessive. In being able to react this way, we are already in the process of reconstructing meaning.

Depending on what has happened during a traumatic event, we sometimes hear victims speak of miraculous protection. What dominates here is the astonishment at still being alive, when others who have gone through the same experience, are either injured or deceased. This reaction shows that the person has been shaken in his/her deeper self, in his/her beliefs or disbeliefs. It is a survival reflex but also a sign that these events disturb their usual points of reference, and question them in the moment but probably also more durably.

By respectfully listening to their reactions, victims of shock can be helped to progressively reorient their lives by spiritually integrating the event. The experience of a non-judging presence can also lead to the possibility of revisiting the experience without shame or guilt.

What presence and what role for the spiritually accompanying person ?

The importance of interreligious collaboration

Considering the diversity that marks our societies at the beginning of the 21st century, disaster interventions will consequently affect people from various spiritual and religious traditions. The collaboration between the representatives of these various traditions is essential.

On a number of occasions we have observed that, in distress and emergency, this collaboration is realistically possible. However, our unit cannot depend on crisis situations and it seems essential to take time, with specific training, to get to know and recognise each other.

Thus we can determine what are the priorities in our common concern for human beings. We can also undertake complementary interventions using the diversity of resources and charisma which this coordinated action allows.

A common intervention with psychologists and other help professionals

As we have already written in previous chapters, those who are called to be present in a reception center during a particularly traumatic event are not there to deliver a “technique” or a “science”, but mostly to provide a human presence. Nor must they undertake therapy in this situation, also “spiritual support” rules out proselytism or any attempt to use the misfortune of the people they meet. It must be reminded that it is the person receiving help who determines what will be offered to him and not the opposite. The badge detailing the identity and the qualifications of the person offering support will certainly be important but must not be decisive.

Thus, “spirituals” and “psychologists”, as well as other people present at the reception cell, come together in offering a respectful presence. It is human involvement that is most important and provides united support to suffering people.

Collaboration will be facilitated if the different members of the cell have learned to know each other and work together. In Geneva, the interreligious disaster intervention group is represented in the pilot group of the reception cell. That is where one must look to design training and collaboration models that can be useful to reinforce cohesion in the interdisciplinary team during an intervention.

Availability of skills

If it is impossible to draw precise lines between psychological support and spiritual support, it is however possible to note certain skills that emerge from our collaboration in the cell. We will briefly name a few:

Confrontation with suffering and especially death

These unavoidable realities of humanness are of course those which bring up the ultimate questions. Religions try to give neither explanations nor definite answers, but a certain outlook and direction which should help the person to face up, without avoiding or eclipsing what is painful or disturbing, and also to sketch open doors and possible hope for the living and the dead.

Making room for silence and contemplation

Contemplation and silence can help us to find our own spiritual resources deep inside. That is why we have underlined the importance of providing, in the reception place, appropriate areas of quiet, away from the rush and noise. The silent area should be clearly indicated and simply designed.

Planning rituals

Those who desire to should be able to take part in the rituals which participate in their reconstruction. In the various religious traditions, funeral rites allow us to publically express our suffering – in keeping with cultural codes– to leave what would otherwise crush us and to live with others who share the same suffering.

If our concern for the victim's inner circle is a priority, we must not forget that the brutal confrontation with death which occurs during disasters also affects rescuers, professionals and volunteers who participate in support teams (chaplains as well), and sometimes even the whole population of a neighbourhood, a region or a country.

It appears important to quickly organise, in connection with local churches and religious communities, ecumenical or even inter-religious services, allowing various sensitivities to be expressed while gradually pronouncing a Word that acknowledges the pain, and opens gaps in the lack of meaning.

Of course this is only the beginning of the process, but the funeral ritual or appropriate rites encourage its launching. To be convinced of this, we must only realize how difficult it is for families to have missing a loved-one whose body has not been found, and this often prevents the necessary ritual which initiates the mourning process.

For those who need it, religious communities, sometimes in collaboration with other professionals, offer a follow-up in the form of "talk groups" for those who mourn. This community approach usually means offering people support so they can express their feelings all during the mourning process, gradually integrate shock and death into their reality and, from there, find ways to start life again with the wound or absence that will forever mark their existence.

The ability to live in uncertainty and chaos and to pronounce a Word naming this reality

Chaplains, who are often leaders in their communities, are accustomed to talking and "handling" silence in dramatic and trying situations for individuals or groups. They know that in chaotic situations, something must be said to create a link with reality and other people. Even when there is nothing to be said, it must be said!

To allow individuals and groups to live through the doubts and uncertainties which are generated by disasters, we believe it is best that chaplains be associated with the preparation and transmission of information.

Deep concern for the human being, respect for all the dimensions of a person, respect for humanness, for religious and spiritual sensitivities, this is what is offered inside the reception cell in disaster situations.

One BUT remains essential, one that forces to great humility. Indeed, whatever we have been able to plan, organise and accommodate, it is necessary to remember that disaster will disorganize all that has been planned. It will push us beyond our limits and our claims to organise chaos. This reminder is healthy, it invites us to greater humility.

The bindings of death had surrounded me
And the worries of the journey of the dead had reached me;
I had reached the bottom of distress and hurt
But I invoked the name of the LORD:
Please LORD, save me!
The LORD is lenient and just,
Our God is compassionate
The LORD keeps the simples;
I was weakened, and he saved me.
I return to my peace,
Because the LORD has made me better.
Yes, you have freed my life from death,
My eyes from tears, and my feet from the fall.
The Bible (Psalm 116)

8.2. Of the legitimacy of spiritual support (Michel Berclaz)

This training manual for intervening people in crisis situations is called “trauma and intervention, the spiritual and psychological support” because defining an intervention requires us to define what the intervention is about.

At the time, the subject of intervention seemed to be the traumatism. We had spoken a lot of this concept; we had described its outskirts and content, its reactions and its symptoms. Psychotherapists used to receiving people still suffering, even years afterwards, from very ancient wounds, dreamed of being able to create a response, during and just after these events, a response that would prevent the development of such distress. These methods have been created to try and fill this preventing function, to try and relieve these wounds. We had thought and theorized around the “Trauma and the intervention”. We did not need much time to realize that:

- our interventions were not about the trauma, but led us to take contact with individuals, with their differences, their distinct histories and that
- the range of our actions was very limited in the face of the distress

As psychologists, we know the human development well, emotionally as well as intellectually, the construction of oneself, the construction of the thought. As clinicians, we have studied the various forms of suffering and various pathologies. We know how to observe, test and diagnose. We know perfectly well the possible effects of these events on a person. As therapists, we are used to working with people suffering great pain. We have learned to meet, accompany. We master communicational and relationship tools to support the person in his/her evolution and the overcoming of his/her difficulties, but mostly, we have learned to protect ourselves from the devastating effect of contact with emotional overflowing. We have developed skills allowing us to create a relationship with the person, contacting his/her suffering, without being turned over by the waves it produces. In other words, we have learned to take the necessary distance… we believe we are the best people to intervene in the immediacy of dramatic events and catastrophes.

At time already we realized that the reactions associated with critical incidents were not diseases, that our interventions could not be treatments. Very quickly we had to admit the range limit of our interventions and the vanity of our intentions concerning preventive measures. It is for these various reasons that we have decided to name the chapter “**psychosocial support**” instead of “medico-psychological intervention”. We thought we were the right people for the intervention, but the latter would concern the social aspects a lot more than the psychological. In this sense, the term psychosocial came as a counter-song on trauma and intervention. We then presented both sides of ambivalence, on one hand the professional side and the scientific considerations, and on the other the human in his social context.

Finally, the experience of these particular encounters has led us to realize the importance of a dimension that was usually unexpected for us. Indeed, confrontation with death, because we have come close to it or because people close to us have died or seen someone die, leads the people to ask themselves deeply existential questions. These questions that we do not often ask ourselves, these questions that we look at from a theoretical angle, with distance or with intellectual passion, when we asked ourselves those questions, in these situations of drama and terror, emerge with an intense acuity, a total actuality. They occupy all our mind and require an answer.

When we fully realise how our lives are likely to stop at any moment, when we are confronted with the unthinkable, the death of our child for example or when we realize the full scale of the atrocities that the humans bring on other humans, it brings out obvious questions like:

but if life can stop this way, what is its meaning, what is its purpose?

- What can well be the point of existence, if it must be so painful and end like this?
- Finally, what happens after life? Is death the end of everything, it's unthinkable, what happens next? Where is my child now? Is he cold, hurt, afraid? Can he see us or hear us? Could we say a few words to him, ask him a few questions we were not able to when he/she was alive?
- Why us? What if we had been chosen for such a destiny, who chooses?
- If there is life after death, if someone chooses our destiny, who does?
- But if God exists, why does he put me through this? How can God let people do such horrors?

And in the absence of a satisfying response, we can hear calls of anger, and rage or pain such as:

- God does not exist, I hate him!!!

Thus, after the psychosocial, these existential questions open another dimension, **the spiritual**. We should have expected it. Don't we say that the social and religious structures appear in the phylogenetic development from the moment when the mortuary rite appears, this implies the realization of the passage from life to death, of the absence of an individual in the group, of the space this absence creates in the people close and the fear that this passage brings up in the living.

Apart from this individual aspect, we will observe that a catastrophe creates a rupture of the link, a break in the inside of ourselves and between us and the others. A break in trust in the other, a loss of self-confidence, beliefs, and values and finally, the loss of necessary illusions that allow us to live more comfortably in existence. That is the real traumatic suffering, not in a clinical sense, but in its deeply social and human dimension.

We know that the person, during and after such situations, is under a great risk of becoming hypersensitive, vulnerable, irritable, distrusting and finally hostile. His/her suffering, with time, irritates his/her close family, aggresses them and makes them live with a constant feeling of helplessness. The individual distress progressively attacks the link between the people and yet, it is through this link that the easing of the pain can start.

What are we outside of our social groups and communities?

The answer to bring takes its source from social and spiritual values, such as the preoccupation for the other, solidarity, alliance between people fighting the obstacles of existence, pain, solitude and especially distress. That is the meaning of psychosocial and spiritual. The immediate and post-immediate support takes its legitimacy from the necessity (or even the duty) for a social group to surround and accompany their members in moments of intense pain (as for times of joy).

Until recently, this was the exclusive function of religious communities and their guides. Without entering a debate concerning creation and the creator, if religions had been "invented", it would be specifically for these circumstances. Their legitimacy must therefore not be debated.

If we base ourselves on the existential questions cited above, we must admit that the leaders of religious communities are the best suited to accompany people issuing these questions. Psychologists, who try and understand the living, are often poorly armed to treat the nonliving or the afterlife. These existential questions are looked into through a spiritual process.

However, the psychologist, through his knowledge of the functioning of the living and its nature can spot the hazards produced by distress on all the implicated people, as well as the intervening people. For example, noting that a dramatic catastrophe situation will take a person from "subject" of his/her existence to "object". Being a victim implies losing control and command of our existence. The victim loses his/her free will. He/she does not do what he/she wants anymore, he/she is the object of the will of other ill-intentioned people.

Volunteering, good intentions, the desire to help (associating the intense need to free ourselves from this feeling of helplessness) will make the victim go from the state of "object of the ill intentions of an individual" to the state of "object of the good intentions of the intervening people". This state is certainly preferable, however it doesn't allow the person to lose his/her status of "victim". It keeps the person in a situation of dependence. The real change can only reside in the accompanying of the individual towards the return to the state of subject. We rediscover the specialty of the psychologist who directs his work towards the autonomy of the individual and who values interdependence instead of dependence.

Any intervening person, be he “spi” or “psy” and however pure his intentions, takes the risk, through his intervention, of substituting himself to the person or his/her natural environment. In the need that he feels to fight his feeling of helplessness, he can try and increase his own personal command and control of the events and of the people, pushing the victim towards dependence and disqualifying his/her close family. His/her need to be useful and efficient may nourish his/her own narcissism at the expense of self-esteem of those for which he is intervening.

This mistake could take the shape, for a psychologist, of a tendency towards “therapysation”, to under-estimate the skills and means of the victims, and for chaplains of a shift towards pre-thought answers and proselytism.

Thus, as for the psychologist, the priest, pastor, rabbi or the imam must distinguish the teaching or the religious message from the simple accompanying in a spiritual thinking process and the resources that the person can take from his/her own beliefs.

The “religious” which would be defined by a family of beliefs and dogmas pre-defining the link between the human and the sacred, or he who mixes rites, beliefs, faith and superstition doesn’t have his place in an official organisation of support in crisis and catastrophe situations.

Etymologically speaking, if by “religion” we chose the Latin root **re-ligare** (re-bind) and that we see it as the relationship between human and the divine, we are not far from the spirituality while coming dangerously close to proselytism. However, if it is the relationship between humans, it is very different. If we chose the root **relegere** (re-read) in opposition to **neglentia** (not care for) or even Cicero’s **religio** (scruple), we evoke the idea that the scrupulous observation of rites and the fear of unnatural forces, we return to dogmas and superstition.

In Japan or China, the term religion corresponds to the combination of two sinograms designating, for the first one: a group united by the cult of the same ancestors; and for the second one: “a teaching” or “school”. Again, if the reunion of a group around a same belief can seem meaningful, there is no place for a religious teaching in a psychosocial and spiritual process.

The **spiritual process** to which I refer, does not necessarily belong to the institutionalized frame of a given religion. It designates an individual or collective thought, about the life of the mind (relative to the existence of an order of reality different of that of the physical body). Beyond the rational, the moral and the psychological, this process tries to accompany the individual or the group in the meanderings of existential questions, without trying to explain or convince, but with the exclusive intention of allowing the person to renew their contact with their resources that need to be mobilized in times of distress.

The rites, when respectful of various beliefs, in the tolerance of differences, are often very useful in the sense that they gather individuals in the happening of the events and sometimes to mark the end of it, while leaving space for the expression of emotions that are attached to it.

In conclusion, everyone fulfilling one’s own role in social support is everyone’s affair. The “spi”, the “psy” as well as all the others, can find their legitimate role around a common objective which would be to enable the mobilization of individual and collective resources, as long as they can control their natural tendencies to want to control and compete with the other intervening people.

Beyond the wealth of knowledge and diversity it brings, pluri-disciplinarity allows us to offer choices. In this context, the choice is in no way trivial. Indeed, as we have seen above, the victim is put through events, sufferings and constraints. The person has momentarily lost his/her free will. Being able to choose means gaining freedom. When the choice is free, enlightened, without strategy, a great step out of the state of “victim” has been made. What choice can we offer?

- Do you need support or not?
- Do you accept to make contact with us?
- If so, do you prefer a chaplain, a psychologist or someone else?
- If you want a chaplain, do you have a preference on the particular religion?

For there to be a real choice, the victim must know to whom he/she is talking (the intervening person has presented himself/herself with his/her name, function, belonging and should wear a badge at all times) and the possibilities should be formally offered to him/her. But again, if it is the case, pluri-disciplinarity becomes a fundamental tool. It is the source of enrichment and it allows the priceless opportunity that is choice.

9. PSYCHOSOCIAL RESPONSES TO CANADIAN DISASTERS 1979-2001: WHAT HAVE WE LEARNED ?...

by Raymond LAFOND

9.1. Presentation Outline

Emergency planning in Canada was very much influenced by emergency planning in the United States and had a unique focus: responding to nuclear war. Most of the courses at the Emergency Preparedness College in Arnprior were centred on how to respond to a nuclear explosion in a community. However, in 1979, a major disaster occurred that changed the focus of emergency planning in Canada: the Mississauga Train Derailment, which caused the evacuation of 233,000 people. Everyone in Canadian emergency planning circles realized that Canadian communities were not prepared to respond to natural or human caused disasters that could originate in their own back yard. Emergency training at the College was completely updated to reflect these new and very real concerns.

How many of you woke up this morning saying: “Today is the day I am going to die? None probably. Why? Because of your “illusion of invulnerability”. What do we mean by this? Human beings have or hold core beliefs or assumptions about themselves, human nature, and the nature of the world. These basic assumptions, that we hold at the core of our internal world, guide our day-to- day thoughts and behaviours. These basic beliefs generally go unquestioned and unchallenged. These core assumptions are the world is benevolent - world here means people and events - people are good, kind, caring, and helpful and events usually have positive outcomes the world is meaningful - that is, good things happen to good people and our own self-worth - general belief in our own goodness, decency, morality and competence.

Ronnie Janoff-Bullman who is a leader in the development of this personal theory of reality explains that these core beliefs are not so much “illusions but over generalizations”. Traumatic events such as a disaster or car accident or any other event that profoundly threatens our well-being, being robbed or raped, shatters these basic assumptions. A person who has been traumatized suddenly comes to the realization that the world is not benevolent, not safe, that events can kill you; she or he begins to doubt that the world is meaningful and that only good things happen to good people; perhaps, the event occurred because the person is not good. Doubts creep in about one’s own self-worth.

These core assumptions about the world and about ourselves influence, I believe, our attitudes about emergency planning, about maintaining a state of readiness. What happens is that we easily transfer these illusions of invulnerability to our community, to our institutions, and to ourselves. Obviously, disasters do happen and communities have to be ready to respond. To do this individuals and communities must overcome a natural resistance not to plan and through risk identification and analysis prepare community emergency response plans, including psychosocial response plans. I’m glad to report that most communities across Canada do have emergency response plans but few of them have psychosocial response plans.

We have numerous examples of what happens to disaster victims and responders when a community or province doesn’t have a Psychosocial Service Response Plan or network to call on when a disaster occurs. Let’s examine what a few Canadian disasters have taught us in matter of psychosocial services and interventions required and how we have applied the lessons learned.

9.2. Bring Families Together

The first lesson that the Ocean Ranger disaster taught us, was that when a major disaster occurs involving the sudden loss of people, especially in an explosion or transportation accident the first psychosocial response should be to bring the families of the deceased or injured together as soon as possible. The benefits of doing this are immeasurable for family members. Here's why:

Bringing families together allows the people affected to interact with people from their own community, province, country who have experienced, and continued to experience the same crisis, and through this contact, this trust relationship, share with one another the pain, the shock, the losses or hardships experienced *thereby defusing some of the trauma through mutual support*. This was especially important for the Kosovars who needed to interact with people from their own country and culture; who needed a safe and secure environment, and time to get to know and trust Canadians.

It is essential that family and relative be in an environment that makes them feel safe and secure, an environment where their traumatic experiences are regarded as normal given the circumstances and fully respected. Private rooms could be made available so families can grieve privately or receive emotional support.

Once families are over their initial shock, they will demand information from authorities as to what happened. Government, company, and investigation officials can meet privately with families at the site where they are assembled - (Fire hall in Stellarton following the Westray Explosion, a banquet room at the Lord Nelson in Halifax following the Swiss Air Crash) - so they can be the first to know about what happened to their loved ones: if they are dead and missing, trapped and awaiting rescue, presumed dead and missing or dead and awaiting identification. Rescue can take a week or more (Westray) and body identification may take months (Swiss Air September 3 to December 6). They can also ask questions or make statements of their own.)

Bringing families together will also allow them to be protected from the media who sometimes become one of many sources of stress. Media relations were very smoothly handled by provincial media relations staff following the Swiss Air Crash. Media were asked not present themselves at the Lord Nelson nor to congregate near the hotel. They were informed that regular news briefings would be held at the Halifax Conference Centre and that they would have access to officials from the Canadian Transportation Safety Board immediately after they had briefed family and relatives. In the five days, I was in Halifax, I never saw any media persons at the Lord Nelson. The media were present in droves (300 media representatives) in Peggy's Cove but there again respected the privacy of mourners. The media was also very respectful of people's privacy at Stellarton. A Lutheran minister regularly met with the media to answer questions and share some of the families' reactions and concerns.

When families are together they can more easily be consulted and involved in funeral services or memorial services.

Once families are over the initial shock, they may want to take legal action against whoever is responsible for the death of their loved ones. Being together allows them to consult one another on legal steps to take. (e.g., St-Basile-Le-Grand - hired their own experts to review soil, water, and air samples and report to them.

Psychosocial information can be made available to help normalize and validate their reactions and explain some of the common reactions they can expect in the days to come.

Family Support Workers, Clergy and other appropriate workers can also be available to assist families.

Inquiries, Coroner's Inquest, Trial

Bring families together at one site and offer emotional and social support to families during the Inquiry Set up a place where they can be together on their own (hotel ballroom, church hall, community hall ...What about the Air India trial that is going to take place in Kamloops in February 2002. Will there be emotional support?

Grieving

If there is one overriding emotional reaction that permeates disasters from beginning to end, it is certainly grief. Disasters are primarily about grieving losses of all types:

Loved ones

Threat of death, destruction

Health

Belongings

Animals

Employment

Living environment

Dreams

Trust

Innocence

Courage

Losses often remain invisible - Victims sometimes don't realize for weeks, months, years what their losses really are. Losses are not immediately recognized because they are not immediately experienced. They surface gradually as people journey through the event. One can experience a loss of innocence when dealing with insurance adjusters, contractors; experience a loss of trust in government because financial compensation is much lower than expected; experience a loss of faith in the justice system when company executives go unpunished, criminals are set free; loss of courage, of strength to rebuild...

Grief Information Updates - One major lesson learned is that information on grief must evolve as survivors move from one phase of a disaster to another. You cannot provide a one time brochure or workshop that explains everything about grief because each disaster is unique and psychosocial information provided must be attuned to this unique experience. As people come to a realization of the extent and severity of their losses, psychosocial workers have to be there to inform and support them appropriately. Thus the need for grief information updates.

Grief topics - Grief information material can cover a number of topics. For the families of the Ocean Ranger it would have been important to make them aware of the particular grief that is experienced when a body is not recovered, e.g., the denial that the person is really dead, the vacillation between despair and hope of reunion. The difficulties of initiating grief. As with so many other situations, the individuals will often provide insights as to the difficulties they are experiencing:

The following account illustrates the unrealistic hope and fantasies that the wife of an Ocean Ranger victim had long after she knew her husband was dead:

"I just didn't want to believe it. There was no proof of anything and it seemed so unreal, His body wasn't found so that made it so much harder for it to sink in. I kept thinking about the lifeboats that weren't found. And once - it was months later - there was an announcement on the radio asking boats to watch out for a lifeboat that was spotted somewhere. Little things like that would give me hope, just to be let down again."

Information can also be provided to families and friends on how make the death real: sending sympathy cards, flowers, planning a memorial.

Innovative Approaches

Newsletter - When disaster victims are separated by long distances, a newsletter where families can share stories, memories, voice their anger, suggest ways of coping, list resources that can help is an excellent way of managing grief. The newsletter can include articles about the times of the year when grieving may become more intense - Christmas, birthday, wedding anniversary, children's birthday.

Information on children and adolescents and how they grieve. Developmental differences - Practical advice about how to deal with typical children and adolescent reactions - See Personal Services Manual)

Sharing of experiences by a person who has experienced a similar loss - One innovative way of helping is for a community or group to invite someone who has experienced similar losses to come and share her grieving journey. This is precisely what took place in Barrie in 1985. Louise Allen, a grief counsellor from Windsor, lost her husband in a freak tornado that struck Windsor in April of 1974 killing 9 people and injuring 30. Louise was invited to Barrie Ontario in October 1985 to speak about her experience. She was interviewed on the local cable network on the grief associated with a tornado. The interview was taped and, on several occasions, viewers requested that the interview be replayed. Simple, creative, inexpensive, non-threatening community-wide outreach. Helps family members, relatives, neighbours, and greater community understand the various grief reactions people can experience in a disaster, how they can express these and how they can cope. Tape can be used for a call in program to discuss reactions, community resources available, need for self-help groups.

What if no one is killed? - Sometimes no one is killed in a disaster but people nonetheless experience grief reactions over a prolonged period of time. This was the case following the Perth-Andover Flood of 1987. No one died but homes were destroyed and possessions accumulated over a life time were destroyed. How do you reassure people who are confused about their grief reactions that its okay to grieve a lost object. A newspaper article on the subject is an excellent start. The media, in my mind, must be integral partners of any psychosocial response team. Such was the case in Perth-Andover. Here is what the Hartland Observer had to say in an article published on the subject: " ...

CBC produced an excellent documentary entitled "Frozen in Time" on the grieving reactions and means of coping of three women who had lost loved ones in an air disaster: one was the wife of a man who died in the crash of Swiss Air 111 and the other two women were mothers who had lost daughters in the terrorist explosion of Pam Am Flight 103 in Lockerbie, Scotland. These type of documentaries can help later on in disaster when families are comfortable with their grief.

9.3. Disaster Funds

Provincial governments need to have specific guidelines on the collection, application procedures, qualifying criteria, administration and distribution of moneys collected. Who should collect the funds? The banks, the Red Cross or a special foundation set up for this. Who can apply? Can those who have insurance to cover their losses apply for items not covered by their insurance, e.g., trees, gardens, landscaping ...

Disaster funds can be demeaning. Disaster victims often feel like welfare recipients who have to justify need before they can receive assistance. Disaster funds can be the source of community conflicts. How should the money be divided? Who should receive money? What are the qualifying criteria? Such was case following the Barrie Tornado when victims who did not have insurance where, at first, excluded from receiving any money. Why? They should have taken minimum precautions. Only the prudent should be rewarded. This was soon reversed by the chairperson, a wise and kindly retired town councillor of 70 years. Usually, if people do not have insurances, its because they are poor, unemployed, ill, and can't afford it.

9.4. Support Community Initiatives

Many of you are familiar with an overhead that I use to describe the star agency complex. I will be showing that overhead in a few minutes. Sometimes initiatives to help families affected by a disaster have no link to disaster psychosocial programs. This was the case with the Ocean Ranger Families Foundation

The Ocean Ranger Families Foundation. Here's how Patricia Hickey describes how the foundation was organized and what it was like at the first meeting:

"When I moved into the second stage of trying to cope with the reality of Greg's death I started to get involved with some of the Ocean Ranger families. That came about some two or three weeks after the disaster. A group of community people got together and formed a steering committee. We received a letter from the Inter-Church Commission signed by Reverend Ralph Billard. They had set up a meeting and invited as many families as possible to attend. Up to that time I only knew two of the families involved. We went to the meeting and there was a good turnout. A lot of the families met each other for the first time. There was a lot of crying and a lot of sad stories told. I think the forming of the Ocean Ranger Families Foundation was something positive that came out of the tragedy for the families. It was a tremendous help for us in the aftermath of the disaster as we all shared a common interest. I am still a very strong supporter. We could relate to each other very easily event though we were practically strangers. You could relate to them in a different way from your own family and friends; you could really bare your feelings with them. At home sometimes you might keep some things to yourself because you didn't want to cause any more stress and hurt than was already there, so sometimes you kept your fears and frustrations to yourself although you knew it might not be wise to handle it that way." (House, p. 26)

9.5. Community-Based Response

The types of services just discussed require that a community have in place, as part of their overall community response plan, a Disaster Psychosocial Response Team which can respond quickly and appropriately when a disaster occurs. Unfortunately, very few communities outside Manitoba and Quebec have such teams. The reason that Manitoba and Quebec are so well prepared is that they have had the most disasters. Quebec, for example, has 1,200 trained psychosocial responders. Each of their 170 offices has a team to respond not only to disasters but community traumas. Manitoba has also a strong community trauma component. By community trauma, I mean those type of events which may affect a neighbourhood, e.g., husband who kills wife and children and them self, or it could be an event that occurs in a school, e.g., death of a child.

What happens when there is no team? Sometime there is no response whatsoever - the Ocean Ranger and the Gander Air Crash are good examples. If there is a psychosocial response, it sometimes takes weeks to get organized. Why?

Because helping agencies, like communities who have no response plan, are so overwhelmed by the suddenness and extent of the devastation, the complexity of issues that they are not sure where to start.

If they do start they get bogged down by organizational issues of jurisdiction - who's in charge, who should be involved. After the Swiss Air Crash, a DPS planning committee met. There were approximately 30 persons sitting at the table. It takes at least one hour for people at the table to introduce themselves. At this particular meeting, the planning could not progress because a psychologist from New York had flown in earlier that morning and kept telling those present that he was an expert in disaster mental health services and that they only needed to consult him if they wanted to know what to do. What does an expert from New York know about the human service network in Halifax?

9.6. Lessons Learned in Organizing a Disaster Psychosocial Response Team

After responding to over 50 major disasters, Canadian communities have learned numerous lessons about organizing disaster psychosocial response teams. Here are some of the more important lessons.

▶ **Awareness of legislative mandate** - Disaster Psychosocial Services has to become aware of the emergency role and responsibilities that has been assigned to them in provincial or territorial emergency legislation. For the last 45 years, responsibility for Disaster Psychosocial Services has been given to provincial or territorial social services department. Municipalities also include them in their emergency by-laws.

Legislative mandate is essential because it gives DPS legitimacy and access to funding when a disaster occurs. DPS recovery programs are expensive - 1.5 million in Ontario for the Ice Storm of '98 - and government usually channel the money through existing government programs and services.

▶ **Funding for training and preparedness planning** - Once legitimacy has been established, you will need funding for training and planning.

Setting up a DPS Organization or Who's on First - If you don't have a DPS team or response plan and a disaster occurs, get ready for a fight. Now that we need someone to take charge, their may be a battle between departments about who should be in charge: social services, health, public health, mental health, family and children' services ... I call this the "star agency" complex. "Star Agencies" always think they are the most skilled and the best suited to take charge of the response. for a the response and this is their organization chart (Slide ?)

What is required in any disaster is a collaborative approach. It doesn't really matter which agency is in charge since all agencies - government, public, and private - will be asked to play a major role. What is important is that someone take a lead role: social services, mental health or public health.

▶ **Integration in community emergency response network** - Disaster Psychosocial Services needs to be fully integrated in their community's emergency response organization so:

- they can gain sanction and support from other response agencies (fire, police, health - once emergency response organizations become aware of DPS' roles and responsibility in a disaster and they will call on them when traumatic events occur in the community;
- establish legitimacy of activities with other human service related agencies.

▶ **Characteristics of a Community-Based DPS Organization**

Community based - doesn't replace the existing organizations but is built from those organizations, believes that community agencies are experts on their community: the political, social, cultural make up of their community

Inclusive - multi-agency, multi-jurisdictional, includes NGO's , service clubs, private practitioners (e.g., Edmonton Tornado)

Favours a collaborative approach where each agency is asked to contribute to the team - personnel, equipment, money, specialized skills and where agencies are consulted regularly about problems and issues and how they can best be resolved.

9.7. Community Response Approach

Disaster Psychosocial Response is modelled on a community response approach: community social services, community mental health, community public health. The community approach stands in sharp contrast with a "traditional mental health" approach:

"Traditional Mental Health" Approach	Community Psychosocial Approach
Is often office based	Is primarily home and community based - (Outreach approach)
Focuses on diagnosis and treatment of a mental illness	Focuses on assessment of strengths, adaptation of existing coping skills and development of new ones
Attempts to impact personality and functioning	Seeks to restore people to previous levels of functioning
Examines content	Accepts content at face value
Encourages insight into past life experiences and their influence on current problems	Validates the appropriateness of reactions to the event and its aftermath and normalizes the experience
Has a psycho-therapeutic focus	Has a psycho-educational focus
Detailed case records are kept of assessments, interviews, treatment methods	Minimal records are kept except for individuals or families that require additional help and support

Regular mental health services also need to be involved in the DPR. The disaster may, for example, trigger the recurrence of reactions from a previous trauma which need to be dealt with by a mental health professional. Other problems may exist that need the intervention of child protection or of substance abuse counsellor. During the Kosavar Refugee response, three psychiatrists were hired to assist and support the work of the Family Support Workers. It is obvious that in some traumatic events some people may need medication or to be temporarily hospitalized. Psychosocial responders need to know their boundaries and to ask themselves if they could, in an adverse legal action, defend the appropriateness of their assessment and intervention. Always err on the side of caution. If you judge that a persons reactions are out of the ordinary, refer. Training sessions need to include information on PTSD reactions. Some problems fall outside the scope and duration of what is usually a time limited program.

▶ Characteristics of a Community Empowerment Approach

If Canadian psychosocial workers have been successful in their many disaster psychosocial responses, it is largely due to their community oriented, community empowerment approach. Listed below are key characteristics of a community-oriented approach.

A community-oriented approach :

- encourages people to help themselves;
- expects people to identify their own needs and to help in the design of response activities;
- involves them in the decision-making and problem-solving processes involved, including health response, psychosocial response, cleanup of their community;
- reaches out to the total community;
- emphasizes psychosocial education and prevention;
- anticipates reactions and needs;
- adjusts plans and services to meet victims' needs;
- reaches out to the community and its victims rather than waiting for them to come to them;
- sets up programs/services as close to the disaster area or community as possible.

Strategies for Implementing a Community-oriented Psychosocial Approach

1) Avoid Treating Disaster Victims as Welfare Recipients

Victims of disasters do not consider themselves to be welfare recipients. They resent formalized, centralized approaches. They want programs or services to be:

exempted from regular processes and routines to minimize delay and "red tape,"(which are sources of irritation) and to be supportive and informal.

2) Disaster Victims Want Programs and Services that are Focussed on their Needs

Disaster victims want programs and services that are set up exclusively for them. They do not want to be serviced as part of regular social services, mental health or public health offices. In their mind, the setting up of programs and services to deal exclusively with the psychosocial effects on individuals, families and communities exposed to a hazardous waste site is a sign that the government takes their health and social need seriously.

3) Full Time Psychosocial Response Team

It is essential therefore that full time psychosocial responders be hired to plan with community members in designing, delivering, and managing psychosocial interventions. Working full-time enables psychosocial workers to gain the community's trust and develop expertise on the psychosocial effects of being exposed to hazardous substances and on appropriate intervention strategies to help people manage these effects.

4) Multi-disciplinary Psychosocial Response Team Members

One major lesson learned in Canadian disaster psychosocial responses is that a community's psychosocial response team must be composed of professionals from various disciplines: social workers, public health nurses, mental health workers, child counsellors, family counsellors, recreation specialist. Each of these persons brings a unique perspective and broad professional knowledge which tends to favour creativity and flexibility.

5) Community-based Psychosocial Response Team

If possible, the majority of the Psychosocial Response Team members should be recruited from the community or surrounding communities. The fact that professionals and volunteers from the community are in charge helps restore a sense of power and control. It also raises the community's overall morale. This does not mean that other professionals cannot be involved but, if they are, they should work in the background.

A community-based psychosocial response team also includes non-professionals and volunteers from the community. It garners the support and involvement of community agencies and other various groups: service clubs, church groups, local neighbourhood groups, etc.

6) A Community Development, Social Services, Mental Health, and Public Health Approach

As stated earlier, the majority of people exposed to a contaminated waste site experience normal psychosocial stress reactions. It is important therefore that a community development, social services, public health and mental health approach be adopted from the outset. Clinical responses are not appropriate because they tend to "psychologies" issues, that is identify sources of stress as lying with the individual rather than being triggered by social issues (economic, cultural, political) and in this case environmental issues. Community oriented psychosocial workers empower people to take charge of their healing. They encourage community members to tell their stories (give them a voice) thereby increasing their sense of personal and community efficacy, competency, power, and control.

7) Examples of Community Psychosocial Response Activities

The types of community psychosocial response activities should be varied and reach out to all age groups. They may include some of the following:

- drop-in centres for youth, adults, the elderly
- recreation activities - psychosocial recovery activities for children where fun can be provided through recreational and social activities
- brochures to validate and normalize peoples psychosocial reactions. These must be designed and written keeping in mind earlier remarks about minimizing people' reactions to the event. A variety of brochures will be needed - for children, adolescents, adults, and the elderly (Health Canada's Office of Emergency Services has numerous samples of brochures that were used in various disasters. The ones from the PCB fire in St-Basile-Le-Grand would be particularly useful)
- newsletters or bulletins have been used on several occasions to give communities a voice in their recovery process. The *Flood of '93 Recovery Bulletin* from Perth-Andover, NB, and the one developed by residents in Maple Ridge, BC, to manage the health effects of a fire in a local dump are excellent examples of a psychosocial education and information response strategy. (Photocopies of these Newsletters are also available from Health Canada's Office of Emergency Services)
- community outreach - this is probably one of the best ways of dealing with the emotional and social aftermath of a disaster. Victims may avoid agencies offering psychosocial services because of the perceived stigma attached to being recipients of social or mental health services. The outreach approach is based on the idea of reaching out to disaster victims through friendly visits which are non-threatening and preventive in nature. Individuals, families or special groups are approached to assess informally their situation and make them aware of community services available. (consult the *Personal Services Manual*, p. 64-65 on how to set up similar services)
- self-help groups to manage stress, self-care, marital or parental issues
- child and family counselling services
- town hall meetings, radio talk shows, etc.

8) Meet Basic Needs First

Sally Leivesly, an Australian disaster researcher and worker, emphasized many years ago what has become a key principle in dealing with the psychosocial effects of disasters and other traumatic events such as exposure to hazardous substances namely the importance of meeting the concrete needs of victims in order to alleviate their physical and emotional responses:

"Disaster welfare planners should be particularly sensitive to the degree to which emotional disturbance after a disaster can be alleviated by practical help with the damage. This is more useful in changing the emotional state of the victim than is emotional support unaccompanied by practical intervention."(Salley Livesley, "Toowoomba: Victims and Helpers in an Australian Hailstorm Disaster", *Disasters* Vol. 1, No. 3, 1977)

Tierney and Baisden, who prepared a major report on *Intervention Programs for Disaster Victims: A Source Book and Manual for Small Communities*, reported that problems considered most serious by disaster victims are housing, unemployment, transportation.

9.8. Victim and Helper Profile :

Key Characteristics & Helping Behaviors of Disaster Psychosocial Responders

Knowing How to Dance - Do you waltz? In a disaster, never lead. Let the victim lead. Let she or him let you know what they need and how they feel. Or ask permission before discussing an issue. (Queen Bee - Carol Sue Rae - Outreach to Families of Swiss Air 111)

Being There - (Bereavement) Being there is more important than doing anything specific. Being reliable and constant and having time just to be with the bereaved are qualities that are highly regarded. ... "Sitting quietly with someone who may be wailing in their distress, or sobbing deeply or lashing out in their anger and confusion is no easy task but one that the social worker can fulfil ... and trust him and use him to help with the rest of the grieving process." (David Tumelty (edited by Philip Seed) *Social Work in the Wake of Disaster*, London: Jessica Kingsley Publishers, 1990, p. 81-83).

Advisor - Knowledge and experience in identifying various stress symptoms and normalizing and validating reactions "does not remove the pain or distress, but it can help remove the fear attached to them." (E.g., fear of being insane, of losing control) .. The perceptiveness also to notice when the symptoms or feelings are beyond the normal experience, and to suggest that medical or psychiatric help may be appropriate, is also crucial."(David Tumelty (edited by Philip Seed) *Social Work in the Wake of Disaster*, London: Jessica Kingsley Publishers, 1990, p. 83).

Critical Incident Stress Management	Disaster Psychosocial Services
Critical Incidents are usually limited event involving more or less homogeneous group(e.g., shootings, accidents ...)	Disasters are usually community-wide events that include deaths, injuries, destruction affecting people of all ages. Disasters are also characterized by a complex aftermath - releif and recovery efforts, newly arising stressors such as unemployment, financial resources, substance abuse, marital and parental issues
Psycho-educational approach	Psycho-educational and social approach
Immediate, short term response	Immediate, short, and long term response
One time response	Short and long term contact with victims
Facilitator-led group process	Individual, family, group, and community process
Structured process	Multi-varied process each with their own varying degrees of structure - crisis counselling, self-help groups, community advocacy, social change, play therapy, occupational therapy
Work setting	Varied setting: morgue, hospital, reception centres, hotels, homes, schools
Address stress reactions resulting from specific event	Address reactions linked to previous trauma an reactivated by the event or to pre-existing mental health disorders
Therapeutic benefit of universalisation of reactions is usually helpful to participant's of a debriefing who experience common reactions	Universalisation may not work in groupings of victims who are in different stages of adaptation

CISD is unlikely to provide effective treatment for complex, ongoing, or persistent problems that are the result of the disaster itself, of pre-disaster vulnerabilities, or the variety of social conditions that surround them.

CISD workers are knowledgeable of the physical, cognitive, emotional, and behavioural stress effects triggered by traumatic events. Their skills and knowledge can be used in short term discussion groups, in stress management groups to educate people about stress reactions, to normalize and validate reactions, facilitate coping and increase awareness of adaptive and maladaptive behaviours. CISD workers can also be included in outreach services to victims.

Most of the comparisons that have just been made are taken from an article by Young and Gerrity entitled : "Critical Incident Stress Debiefing (CISD): Value and Limitations in Disaster Respon (NCP Quarterly 4(2): Spring of 1994.

Young and Gerrity end their article with the following recommendations:

- that the teaching phase of CISD be expanded to include the complex factors associated with stress reactions in a community-wide disaster - this
- they caution against the unquestioned acceptance of CISD debriefing procedures as a sufficient intervention following community-wide disasters
- that debriefing be viewed within its function to address a limited aspect of victims' disaster experience
- that CISD serve as a means to educate participants about other critical factors affecting stress response - social, cultural, political, environmental ....
- that CISD be a means to make referrals to other related resources
- that Disaster Mental Health practitioners use various education-oriented interventions to mobilize and strengthen social networks - e.g., outreach presentations to organizations, institutions, self-help groups, special populations, media programs, hot lines etc.

Conclusion

"*But Who Cares Now?"* This cry of distress, of abandonment, of resentment, of rage, from parents, wives, and children of those who died on the Ocean Ranger has, to some degree, I believe, been heard by people like you here today who are here today to learn more about how you can best help the victims of traumas. You are here because you are aware of what impact these sudden and also slow developing disasters can have on the physical, social, and emotional well-being of those directly or indirectly affected by an event. You are here because you want to respond sensitively, appropriately, and in a timely manner to all those who are victimized by trauma.

References

Bautista, Cynthia Banzon. (no date). The Mount Pinatubo Disaster and the People of Central Luzon. Quezon. Department of Sociology and Center for Integrative and Development Studies, University of the Philippines. http://pubs.usgs.gov/pinatubo/cbautist

Baum, A, Fleming I, Davidson, LM. (1983) "Natural Disaster and technological catastrophe", *Environmental Behaviour*, 15 (3): 333-54.

Baum, Andrew (1991). Toxins, Technology, and Natural Disasters. In Gary R VandeBos and Brenda K Bryant (Eds.), *Cataclysms, Crises, and Catastrophes: Psychology in Action*, Washington: American Psychological Association, pp 9-53.

Couch, Stephen R. (2001). 3 Environmental contamination, community transformation, and the Centralia mine fire.Ihttp://www.unu.edu/unupress/unupbooks/uu211e/uu211e07.html

De Marchi, B., Funtowicz S., Ravetz. J. (No date). 4 Seveso: a paradoxical classic disaster. http://www.unu.edu/unupress/unupbooks/uu211e/uu211e09.html.

Duncan, Garrett (1998). The Psychological Benefits of Wilderness. UK. The Ecopsychology

Institute.http://isis.csuhayward.educ/ALSS/ECO/Final/duncan.htmlhttp://www.unu.edu/unupress/unupbooks/uu211e07.html

Erickson, Kai (1994). A New Species of Trouble: Explorations in Disaster, Trauma, and Community. New York. W.W. Norton & Company.

Gist, Richard, & Bernard Lubins (Eds) (1999), *Response to Disasters: Psychoscial, Community and Ecological Approaches*, Philadelphia. Bunner/Mazel.

Janoff-Bulman, Ronnie. (1992) *Shattered Assumptions: Towards a New Psychology of Trauma*, New York: The Free Press.

Lee, Terrance. (1997). Research in Ecopsychology: Environmental Stress One Decade After Chernobyl An Exercise in Applied Ecopsychology. UK. The Ecopsychology Institute. Echpsychology on Line: New Research. http://isis.csuhayward.edu/ALSS/ECO/Final/research.html

Mitchell, James K. (No date). Improving community responses to industrial disasters. http://www.unu.edu/unupress/unupbooks/uu211e/uu211e03.html

Nuclear Energy Institute (2000). Fact Sheet: The Chernobyl Accident and Its Consequences, July 2000. Washington. http//www.nei.org/doc.asp

Picou, J. Steven, Gill, Duane A. (1996). The Exxon Valdez Oil Spill and Chronic Psychological Stress. http://www.jomiller.com/exxonvaldez/articles/picougill2.html

Roszak, Theodore. (1998). Ecopsychology: Eight Principles. UK. The Ecopsychology Institute. http://isis.csuhayward.edu/ lhttp://isis.csuhayward.edu/ALSS/ECO/Final/intro.html

Ryley, Nancy (1998). The Forsaken Garden. UK. The Ecopsychology Institute. http://isis.csuhayward.edu/ALSS/ECO/Final/garden.

Solomon, Susan D. (no date). Intervention for Disaster Victims: Preserving the Social Network. http://www.emotionalfirstaid.com/volume3/number4/5.html

Simmons, James and Stark, Nancy (1993). Backyard Protest: Emergence, Expansion, and Persistence of a Local Hazardous Waste. In Policy Studies Journal, Vol. 21, No. 3, pp 470-491. http://copa.org/bbs_file/backyard.txt

Tucker, Pamela http://www.atsdr.edc.gov/HEC10n1-h.html (2000). Scientific Research Continues on the Psychological Responses to Toxic Contamination. In Agency for Toxic Substances and Disease Registry – Hazardous Substances and Public Health - United States Department of Health and Human Services - Spring 2000, Part 1. http://www.atsdr.cdc.gov.http://www.atsdr.cdc.gov.

UN Chornobyl Program Project. UN Chornobyl Programme Project Document. (No date). http://un.kiev.ua.:8080/chorn/project.htm

US Department of Health and Human Services, Agency for Toxic Substances and Disease Registry, (1995) *Report of the Expert Panel Workshop on the Psychological Responses to Hazardous Substances*, http://www.atsdr.cdc.gov/HEC/PRHS/

World *Health* Organization (1997). Before, during and after radiation emergencies. Copenhagen: WHO Regional Office for Europe. http://www.who.dk/tech/eh/ehs02e.htm

10. OCCUPATIONAL HAZARDS AND SELFPROTECTION

10.1. Reactions in intervening professionals

In brief, we should remember that the intervening people in contact with victims seem to present less risks concerning PTSD than the average population. They are however threatened by cumulative or somatic stress and its consequence, professional exhaustion. If their sources are distinct, their signes are relatively similar:

Thus, the reactions due to professional exhaustion are close to those of PTSD. However, professional exhaustion is generally associated with the loss of a certain number of illusions or ideals concerning, for example, the range of our work, its evaluation by others (non recognizing of accomplished tasks), institutional or hierarchic support as well as the unbalance between granted efforts and perceived rewards. This point will appear in the following subdivision.

We can recognise the emotions of our interlocutors through the perception of verbal, para-verbal and non-verbal elements. However, our body also seems to work as an antenna. We feel the emotion of our interlocutor inside of us.

Giacomo Rizzlati, of the University of Parma, discovered, in the 90's, that neurones from the premotor cortex that are activated when we are observing an individual doing something, mirror neurones. This discovery, a subject of studies currently in development, concerning mirror neurones notes that:

- Their activation is essential for a correct and experiential understanding of the observed action;
- it makes learning and imitation possible,
- it allows to understand how, why and the intention of the action,
- that mecanism is also implied in the ability to percieve the emotion felt by the person (empahy),
- the actions executed by the subject become messages understood by the observer, without necessary cognitive mediation.

Therefore, it is difficult to distinguish what is peculiar to us or what is the product of the other on us. We run the risk of acting from these emotions.

As would say Dr. Herman, let us suppose that the trauma is contagious. In their role of witness of disasters and atrocities, the professionals live in emotional overflow and are likely to share identical feelings as those of the victims and their families, such as sadness, distress, anger, range, hostility, helplessness, the need for recognition or even confusion. This mirror effect, form of "emotional sponge" can lead the intervening professional to inadequate behaviours like: to take a side, play the lawyer's role, claim recognition of their work or their own suffering. Finally, their anger can be directed not only towards the potential aggressors, but also to colleagues, other intervening people, the institution, the organisations or even towards themselves. These are their own reactions and are therefore perfectly natural. This phenomenon is qualified as "traumatic counter-transfer" and we will name it "**mirror response**".

10.1.1. Identification to the victim

This way, the intervening professional can feel: anger, rage; frustration and irritability; indignation.

This anger can be directed towards the aggressors but also towards other involved such as colleagues, the institution or even oneself.

- acting through anger, we can share the hostility of the other;
- we can stop being impartial and victimise others;
- acting through helplessness, we can:
  - be neutralised,
  - defend ourselves from it, becoming to active (lawyer, defender)…
  - and the more active we are, the less the person has the opportunity to be.

However, the professionals identify not only to the victims and the helpless witnesses (thus producing a feeling similar to the "guilt of the surviving") but also the potential aggressors. This phenomenon can take several forms, such as:

10.1.2. Identification to the aggressor

through different forms such as:

- doubting the victim's comments;
- tendency to minimise, trivialise or rationalise the abuse or the situation;
- feeling repulsion or disgust for the person;
- present value judgments;
- becoming overly aggressive, hostile or violent;
- feeling a voyeuristic interest, or even fascination.

Moreover, the repeated exposure to expressions of greed and human cruelty inevitably

- undermines self-confidence, trust in our own professional skills, the meaning of our work;
- makes us vulnerable and spoil our trust in the most intimate relationships;
- makes us cynical and brings us to doubt the motivation of others;
- produces a pessimistic look on the human condition;
- alters our feeling of basic security, the positive value of oneself and of the relation,
- shakes the faith and beliefs, and finally produces an existential crisis.

Even though these reactions are perfectly natural, the professional must be able to control the drift; to guarantee a better work quality, a better efficiency, and develop relational aptitudes with colleagues as well as the beneficiaries of the support. To do this, a certain number of tasks can be useful, they are organised in three categories: dealing with resources, auto-protection and co-protection.

10.2. Professional exhaustion : burnout

We have the sources and effects of stress above. Seyle (1975) had developed the concept of "General Adaptation Syndrome" describing on a biological level, how stress could have an incapacitating effect on the individual. He described three levels:

1) alarm

2) resistance

3) exhaustion

On the long term and in a repeated fashion, the reaching of the third level can lead to professional exhaustion:

The reactions peculiar to professional exhaustion (burnout or burning out) are hard to distinguish from anxious, depressive or traumatic disorders. However, professional exhaustion is generally associated to the loss of a certain number of illusions and ideals concerning, for example, the range of our work, its evaluation by others, as well as the institutional, hierarchic or generally social support.

In other words, it seems that professional exhaustion is caused by the existing ratio between the quantity of invested efforts and a series of deceptions and frustrations:

- These deceptions are connected to the difference between the representation the person had of their own work and the concrete reality.
- The deception of not being able to do as well as we would have liked.
- Frustration of not being able to do more, of not having or not having received the necessary means to fulfil the tasks in an ideal and acceptable way.
- Frustration concerning criticism or reprimands from colleagues and more importantly superiors,
- A lack of recognition from the institution and sometimes society in general.

<u>Signs of professional exhaustion are:</u>

- Decrease in energy, physical and moral exhaustion,
- Anxious and depressive manifestations,
- Concentration difficulties,
- Difficulties in taking decisions,
- Decrease in self-confidence, trust in others and the increasing of suspicion,
- Relational difficulties with colleagues,
- Decrease of interest in socio-professional fields,
- Strong decrease in motivation for work,
- Absenteeism

10.3. The mirror effect and triangulation

As we have seen, within the occupational hazards there is the mirror effect (traumatic counter-transfer, identification to the victim or the aggressor) as well as triangulation (when we enter a triangulation: victim, persecutor and rescuer). In the face of these intense distress and helplessness reactions, the intervening professional runs the risk of being neutralised or over-active and taking the place of the victim creating a worse feeling of helplessness for the latter.

Indeed, the foundations of psychological trauma resides in:

- confusion
- emotional overflow
- helplessness, the loss of command and control on life
- disconnection with others, the loss or the alienation of connections.

Thus, the recovery relies on the regaining of a certain control, a form of mastery of the person on his/her own existence as well as the regaining of a link or the establishing of new connections. This recovery can never happen outside of a relational context, never in isolation. It consists in regaining, recreating a certain number of faculties such as:

- ► the capacity to trust,
- ► autonomy
- ► initiative
- ► skills
- ► identity
- ► intimacy

These skills have been developed within relationships with others; they must be regained in an emotional frame. The first principle of recovery consists in the regaining of command and control from the victim. He/she must go from the status of object of a situation to the subject of his/her existence. He/she must be the author and the referee of his/her recovery. The intervening professionals, the carers as well as the family can offer advice, support, help, affection or care, but never cure.

We have talked about it before in the chapter concerning the limited supportive sessions, no intervention that would take the person's power could participate in the recovery, even though it would seem to follow the immediate interest of the person. In certain exceptional circumstances, when the person has abdicated all responsibility for his/her handling, or when he/she seems to be a risk for himself/herself or others, a quick intervention is necessary with or without his/her agreement. However, the person should still be consulted, and offer a possible choice, as far as his/her security allows. Moreover, the victim has seen his/her basic confidence seriously altered. He/she must imperatively find an ally in the intervening person. Let's repeat it again, the risk of creating a dependence is such that the latter should be extremely attentive to show himself selfless and neutral:

- **selfless,** in the sense that he must prevent himself from using his power to satisfy his personal needs and where
- **neutral** signifies that he must not take a side in the internal conflicts of the person nor try to direct his/her decisions.

However, the development of such a relationship of trust requires that the intervening person or the therapist explicitly claim a position of solidarity towards the victim. Accepting the isolated status of victim to the person is an essential step towards the creation of a relationship of trust, it is a response to the intense need to be recognized and is probably the only way to overcome the feeling of guilt deeply set in the traumatized person. At the same time, it is an extremely risky position on the long run concerning the door it opens to coalition, over-simplification, or dependence.

To fully comprehend this point, I suggest the reader looks into the concept of triangulation suggested by “Transactional Analysis”. In this approach, the concept of life scenario explains how the behaviour diagrams in our actual life were born in our childhood. It gives answers on how we continue to use the same strategies of our childhood in our adult life, even when these end in painful or vain results. Consequently, the AT suggests a theory of psychopathology. Its most fundamental postulate is based on when people are “OK”, which means that we have, you and me, a value, importance and dignity as people. I accept myself as I am and accept you as you are. This claim concerns the essence of the person more than his/her behaviour (be OK rather than do OK). Sometimes I will not like what you *do*, but I will always accept what you *are*. Your essence as a human is OK for me, even if your behaviour is not.

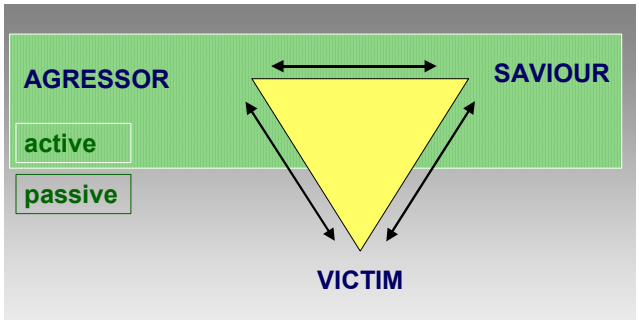
The recognition of the unconscious dynamic of games is the work of Eric Berne. He was the first to work with psychological games as a relational dynamic. He said that games were deplorable but terribly efficient ways to obtain what we need. There must be at least two people to “play” and we intuitively find the partner(s) whose games are complementary to ours. Stephen Karpman conceptualised the “**Dramatic Triangle**”. It helps us illustrate and understand games in a different way. Thus, Stephen Karpmann illustrates the games played based on a certain number of favourite roles, that the players hold unconsciously. We can then encounter the sadness or the confusion of the “**Victim**”, the anger or the triumph of the “**Persecutor**”, or even the worry or the pity of the “**Saviour**” or even “Saviour”. By looking at these three different positions, we must imagine that every person responds to the situation while ignoring the reality of what is happening or what the other person is feeling; he/she only takes account of his/her own perspective and what is going through his/her head. Therefore, he/she does strong misreadings on the capacities of each to react to the situation.

This is how the **Persecutor** and the **Saviour** misread the capacities and the value of others by disqualifying them, and the **Victim** disqualifies himself/herself in the face of others. We are therefore in the presence of symbiotic relationships like “*Take care of me*” (Victim); “*You really are incompetent*” (Persecutor) or “*I will do it myself, you will never be able to*” (Saviour). As we can see, in the dramatic Triangle, the roles are interchangeable. The individuals start to play when they do not receive enough signs of recognition, or that the other refuses to continue. Therefore, the “strategy” used is to change the position in the triangle. We should however recognise that it is not easy to avoid being a victim. We must admit that the other or the elements are often much more powerful than we are. However, if we cannot prevent from being, at a given moment, a victim, we must try and not develop a victim identity. To do this, I repeat the progression in five steps “the steps towards de-victimisation” (the first having been added by Diane Lauzier) are

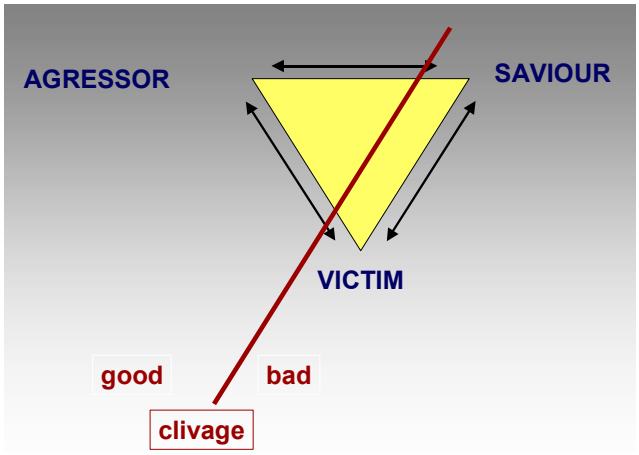
The five steps towards de-victimisation:

- ⇨ re-establish the facts (come out of the confusion);
- ⇨ know how to say no
- ⇨ name what we want
- ⇨ accepting to negotiate
- ⇨ accept separation

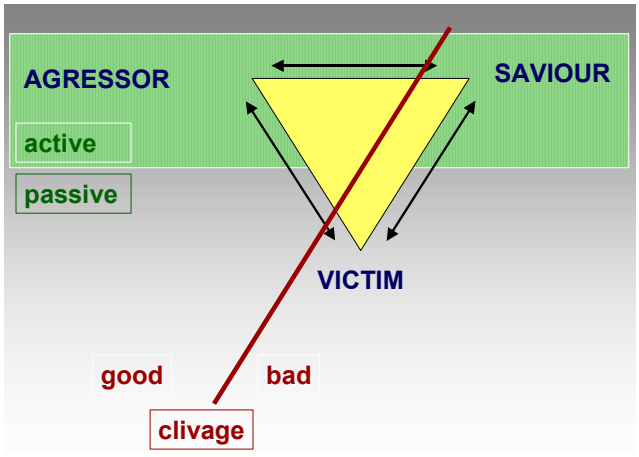
Assertiveness



Clivage good / bad



The superposition of the two models



Therefore, from the triangle of Karpmann, we place the separation categorising the protagonists in actives or passives. We can see that the Saviour and the persecutor share a common tendency to be active.

If we superimpose the triangle of Karpmann, the assertiveness and the notion of division, we notice that the victim defines himself/herself as a passive person engaged in a relationship of dependence with others, qualified as good (Saviours) or bad (persecutors).

The persecutor probably only exists as such in the eyes of the two other protagonists. It is generally an active person who tries to fulfil his/her objectives. However, he/she can also be a passive aggressive condition. In this case, we have a modification of the first category, the victim and the persecutor being part of the same category.

The Saviour shows himself as active (particularly concerning others), presenting a need to be appreciated, he exists in a relationship of dependence with the victim. Moreover, he can practice his own hostile tendencies towards the persecutor, and still stay in the "good" part of the over-simplifying division. It is probably the latter that seals the dramatic triangle.

Diane Lauzier, Canadian psychologist, describes three divisions:

- division in the beliefs concerning the human nature, or the judging of what is bad or good;
- division in the behaviour, as either passive or active, where the rescuer is active the more he maintains the victim in his dependence;
- division of the attitudes in a relationship: handling versus dependence and co-dependence or opposition.

10.4. Dealing with stress

The reader will have understood, stress, in its interpretation by psychiatrists and psychologists corresponds to the overflow of the individual capacities of subject. The handling techniques of stress then aim to:

- mobilise and increase the individual resources
- develop measures of auto-protection and
- work on co-protection (support, solidarity between peers and the improvement of collegial relationships.

Naturally, this process, from the point of view of the employee, is positive, useful and likely to significantly improve the comfort of the person such as the quality of the social connection. However, these handling techniques aim at improving individual and group strategies of adaptation for the situations instead of looking for improvement in a professional context.

Indeed, to act exclusively on the adaptation to the professional context instead of the work condiations corresponds to a massive transfer of responsibility on the employees' shoulders. If this strategy can keep it's meaning in situations in which no mean of action can be planned, it presents a highly perverted characteristic in other cases.

The result of these epidemiological researches clearly show it, the principal causes of stress in the professional field are in the organisational forms of work, management exclusively oriented toward the maximisation of profit. Any solution that would be based on anything other than the organisation structure, management and a handling socially oriented towards human resources would only be vaguely palliative and destined to a disappointing success.

Therefore, the risk, when practicing seminars on the handling of stress, is to use as an alibi and validate a movement of "un-responsibilisation" of the organisation. In other words, to maintain, or even amplify, a functioning that we know as extremely dangerous for the health of the personnel. Practicing this, strictly animated by well-intentioned objectives could, paradoxically, have deleterious effects in the sense of keeping a system that imperatively needs to be modified.

From the point of view of epidemiologists, the answer is obvious, it is on the four components of the model that one must apply the attempts at solution, thus:

1) calibrate the work standards (demands),

2) increase autonomy and the participation of the employee,

3) develop the social support between peers and executives,

4) re-balance the ratio between provided effort and reward.

Which is particularly well summarised in the last paragraph of the Daviezes' article:

« In this perspective, the response to the stress demand does not consist in helping the subject to adapt to his situation. One must analyse with him, at the closest to his concrete situation, the dilemmas in which he is stuck and help him develop his capacity to think, debate and act.»

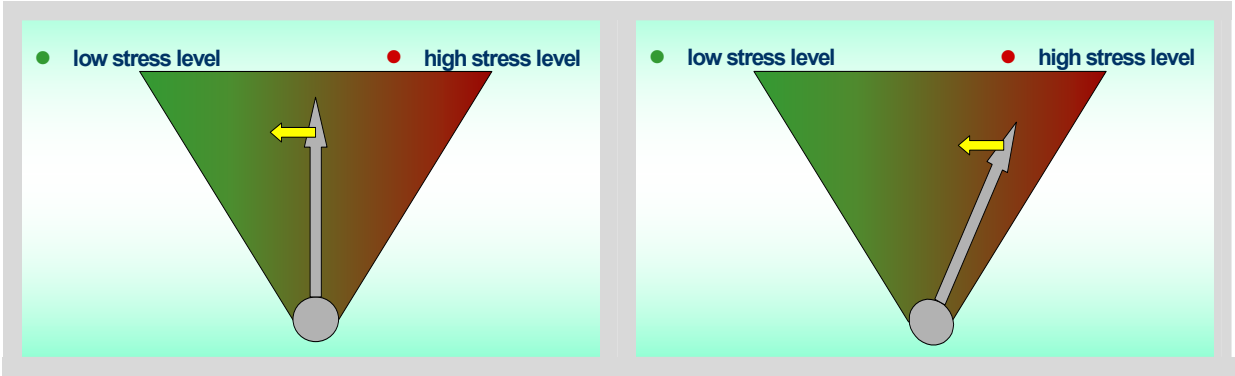
We must repeat it, stress is a natural phenomenon useful and essential to survival. It allows to focus our attention on the difficulties and potential dangers encountered and to boost our physiology so that our body and mind may be able to face them. We do not wish to eliminate it in any way. The task is impossible and if would the result would probably be dramatic. However, as we have seen, the phenomenon can get jammed, the adaptation mechanisms become insufficient or overwhelmed.

To avoid this overwhelming, a certain number of precautions can be useful if not always efficient. Firstly because there is a relation between exhaustion and the availability of resources, working to save and regenerate the latter is an excellent start.

10.4.1. Handling the resources

- sufficient sleep (quality, quantitiy) regular breaks,
- healthy food and sufficient quantity,
- regular rhythm of life, balance between work and leasure,
- respecting our own limits,
- physical exercise,
- avoid alcohol and drugs,
- relaxation techniques,
- massages,
- and all our other individual methods of recovery.

The following table tries to illustrate that with given methods of resourcing (corresponding to the efficiency depending on the yellow arrow) the chosen moment to apply them is determining. In the left table, the methods are applied in a phase of medium stress (orange zone), they will take the level of stress towards the relaxed zone (green). In the right table, the techniques are applied when the level of stress is high… with the same efficiency, the level stays in the red.



We are trying to show that the predominant elements in the handling of stress reside in the spotting of our own level of stress, being aware of the most stressing agents for us as well as the spotting of our most functional techniques and methods of recovery, in order to engage in them the earlier possible, to guarantee their efficiency.

Each of us knows we will need to work our own stress by starting to maintain a certain control over our body. Nearly everyone in possession of adequate information can put themselves in conditions to lighten the stress that affects them. To start off, it is essential to keep in mind the following rhythm:

……smalls goals, small tasks, a day after another……

“What am I going to do <u>today</u> to decrease my stress and do myself some good?”

It is accepted that the keys to handling stress, in a general way, is to be conscious of our own needs. Once taken in consideration, general tension reduces. To lighten stress, what “works” for some doesn’t necessarily correspond to the needs of others. Moreover, the ways with which people handle stress evolve, depending on exterior factors, on the life that surrounds them, but also on their prior experiences.

By having in mind the five following elements for handling stress, and by trying to do at least once every day something for the good of our physical wellbeing, each and everyone will be able to maintain a certain balance, even in the most complex situations.

1. Exercises

It is not always possible to participate in sport, but we consider that an activity that requires your whole body, and lasts 20 minutes or more, with acceleration of the breathing and the heartbeats, counts as exercise. Going up the stairs on foot, gardening mightily, cleaning the house, walking to work are considered exercises. The mind and body are inseparable. It is always possible to find 20 minutes during the day.

2. Diet

Often we forget to eat when we are stressed or we eat in an inappropriate way, food that pleases but are not healthy (chocolate / fried food / sweets etc…). During moments of stress, it is essential to establish frequent and long enough breaks in order for everyone to eat and drink, including hot food and drinks.

Our body presents essential needs: regular meals, easy to digest, containing fruits and vegetables if possible. Unlimited liquids…. Never wait for thirst to drink! Snacks made of fruit etc… We can limit "nutritional" stress by avoiding excess: sugar that exacerbates tiredness and mood changes, caffeine, theine and cola based beverages that are stimulants and prevent from sleep and rest, alcohol that is rich in calories, poor in nutrients, that acts as a depressor and interferes with the absorption of Vitamins B, anti-stressors.

3. Rest and sleep

Stress can influence the sleep, in quantity and quality. The tiredness that emanates from it should be quickly taken into consideration. For some, exercising will quickly re-establish the balance. For others, a mean to "juggle" between moments of rest, going to sleep earlier to recuperate, or take small 10 to 15 minute naps during the day. Resting is an activity in itself, but it can be hard for some people to admit it and to authorise themselves to it. In this case, intervening prevents from exhaustion and disease.

4. Relaxation and simple pleasures…

In stressful situations, granting a moment to oneself can be hard to accept, for our close circle, and ourselves especially when the needs of others, and the exterior situation are deteriorated. It is however essential to take particular and just care of ourselves (taking account of the circumstances, naturally).

There are many relaxation, personalised activities and the small enjoyable moments that each will allow himself are essential. They will enable us to forget the outside stress for a moment.

The techniques to handle stress are as numerous and various as the people that use them, but they share the following qualities:

- they provide a moment of complete control that goes from the choice of the activity to its length as well as its frequency;
- they can allow a person to be alone for a moment: a bath, listening to music, reading a book;
- they can be a source of comforting thoughts, contact with family, friends.

We can also chose shared activities, a card game, a chess game etc. Others will enjoy electronic games. Finally, those who cook will be lucky on two counts, as they will handle their stress by preparing a good meal and please others through this moment of shared relaxed time.

To finish off, contact with nature is an essential source of relaxation. A walk, listening to birds, admiring a beautiful sunset bring a very intense and beneficial spiritual relaxation as well as on the physical level.

All these recommendations and suggestions will be vain if they are not applied in a regular way… and that is probably the greatest effort.

5. Communicate to reduce stress

Each has a way, a moment, a space of choice to communicate his/her stress. It is important to stay in contact with the other and about our experiences and feelings. However, if we are isolated, or that we are going through particularly difficult times, with “distant” colleagues we will need various means to communicate:

- a diary
- letters (sent or not),
- the « Buddy System »
- the « monitoring » of our interior discourse and our thoughts on the situation,
- communication through prayer and meditation

10.4.2. Before and after the intervention

Concerning the handling of stress, we find what relates to a situation in particular and what deals with the measures to take or respect on the long run. For isolated situations, we must note the following points:

MENTAL PREPARATION BEFORE THE SITUATION

- Orientation concerning the mission : “my task is to…”
- Responsibility field : “what are my responsibilities ? What lies with me is…”
- Focusing on the task : “the more important right now is…”
- Difference between daily and commitment : “this is a commitment, I apply my knowledge…”

SELF CONTROL DURING THE COMMITMENT

- Questioning oneself : “can I still work correctly ?”
- Length of the commitment : “the commitment still lasts…”
- Avoiding uselessly oppressive impressions : “what must I be attentive to, or not ?”
- Recovering a calm and deep breathing : breathing deeply, counting to five, exhaling deeply, counting to five,
- Avoiding useless muscular tension : Check your body and release your unnecessary muscles.
- Define the criterion of ending : “the intervention finishes for me when…”
- Orientation concerning what happens next : “after the commitment, I will do the following things…”

All these points aim at focusing the attention on the situation, the mission, the field of action and the individual limits in the case of an isolated intervention. The following page concerns the measures that have to be taken on the medium and long run.

The previous chapter shows it well, occupational hazards are numerous and important, such is the frequency of stress in the profession. Rare are those who can avoid it throughout all of their active life. This chapter aims at presenting a series of means capable of reducing the negative impact of stress on the professional. The well-advised reader will observe that part of these suggestions concern the person and the other on the relationships.

Indeed, it clearly shows that one of the more important impacts of stress is on relationships, although it has been proved that inter-individual relationships, group spirit, trust in social support, are fundamental factors of the individual handling of stress.

10.4.3. Auto-protection and co-protection

From the realisation of the importance of the set up of means to allow us to recover, of the capacity to be aware the first signs of stress, of the evaluation of our state of stress soon enough and of knowing our means to relax, a certain number of elements are likely to enable us to protect ourselves from exhaustion:

Auto-protection:

- Realisation of the state of stress,
- Spotting the stress agents in our environment,
- Evaluate our physical and mental abilities,
- Try to reduce the level of anxiety,
- Make sure we take part in numerous and various activities,
- Develop strategies to manage time,
- Improve our organisation,
- Work on problem solving,
- Stay realist and precise in our interior monologue,
- Develop positive thoughts,
- Avoid, if possible, taking important decisions under stress,
- Try and take a step back,
- Know how to say yes / no, respect our own limits, be able to delegate tasks,
- Be attentive to our own changes (habits, behaviour and mood),
- Contact our personal, philosophical and spiritual values,
- Tolerance and adaptability,
- Manage our frustrations,
- Spot our resources and develop them,
- Nurture positive connections,
- Taking care of our family, friends and social relationships,
- Develop the quality of our professional relationships,
- Nurture laughter and a sense of humour,

Finally, human beings are gregarious: they live in-group. Automatically, the group becomes a mean to protect oneself from suffering, misfortune and also a source of tensions and difficulties.

Health professionals are trying to develop means to reduce, relieve suffering, lower the level of tension and protect individuals against the pathological effects of an encounter with drama, catastrophe and terror. Many methods have been developed without being able to have everyone agree on their efficiency.

However, there is a point on which professionals seem to agree in these researches, they look into the soldiers confronted to the horrors of war and show that: soldiers working in small units, with a good group relationship (friendship, solidarity) under the orders of a “small leader” in which they trust (he doesn’t need to be loved, the soldiers only need to know that he will not put them in danger unnecessarily, that he will go with them and will defend them in the face of the enemy as well as the hierarchy) are much more protected psychologically than others.

We realize to what extent quality relationships protect the individual against the detrimental effects of stress and suffering. It is then obvious to observe that one of the best means to protect the individual lies in caring for relationships, be they social, professional or family-related.

Co-protection:

From the point of view of professional relations, one should set up measures of “co-protection” that could be present in actions such as:

- respecting the tasks of each,
- circulating information,
- avoiding the spread of rumours,
- developing the listening ability of our colleagues,
- manifesting a clear and precise communication,
- encouraging our colleagues,
- trying to know the others better and develop a certain trust,
- recognising our skills as well as those of others,
- being attentive to the reactions of others,
- encouraging the organisation of work in small groups or units,
- developing group work,
- improving and harmonising the relationships with hierarchy,
- asking for supervision,
- organising support groups between peers.

Peers support should offer the possibility to express the emotional reactions (but not impose it either) as well as taking care of technical or ethic preoccupations concerning the professional tasks.

The reader will have understood it that the point is not tricks or universal and unstoppable means to face overflow associated with stress, but a series of measures likely to improve the situation.

We must accept that the measures of improvement of collegial relationships are not easy to bring, especially when we understand that the individual, under stress, becomes tense, suspicious, vulnerable, irritable and quickly hostile. Yet, that is exactly when it is important to do something.

In the same way, it is especially when we are stressed that it is so difficult to engage in methods or relaxation… which underlines the importance of adopting them quickly, before the red zone, while they are still practicable and the most efficient. We must learn to spot the first signs of stress, to evaluate our own level of tension, to sport our individual measures of adaptation and recovery to engage in them while there is still time.

10.4.4. Feedback

Object of the feedback: Feedback allows you to contact your own perception of things and remove the misunderstandings that would have been fathered by certain behaviours. It is not a tool destined to analysis or the transformation of your interlocutor. It gives information that can be precious and useful to the evolution of the relationship and the development of personality. The exchanges it engages contain more personal information if it is the case of a right to respond granted in a reciprocal way. Feedback reflects the values, ideas and feelings of the person that gives it.

Give feedback

Is the addressee willing ?: Always check that the addressee is willing to receive your feedback. Concerning your frankness, adapt yourself to the person : too much uncommon frankness can shock your interlocutor and block his/her will to listen. Take account of the receptiveness of the addressee and the limits of his/her perception.

Choose the right **moment** to give feedback :

He should intervene as directly as possible.

It is when it is the most welcome by the addressee that it is best received.

Content of the feedback : Only give feedback concerning **behaviour** (and not criticism directly to the person) and that is constructive for the interlocutor. Express yourself precisely and concretely ; make the distinction between what is perception, supposition, **interpretation** or emotional elements :

Perception : I noticed… I saw… I heard

Supposition : I think… I believe… I imagine

Felt elements : I felt… I would like

Interpretation : I attribute the meaning or the intention…

Render your reaction comprehensible. Avoid judgements, sticking labels, proceeding to characterizations. Do not judge and do not generalize. Describe an expérience and a past experience by basing yourself on observations and events.

Receving feedback

Ask for feedback : our perception of things does not necessarily correspond to that of colleagues or hierarchic superiors : it is influenced by different factors. That is why you must ask in a concrete way for the information you wish to obtain, relating to a role, a situation, or a given function, etc. Do not satisfy yourself with a global judgment, demand precise remarks, in order to understand what your interlocutor thinks. The chances for a real feedback are proportionnal to your own openness.

Receiving feedback : listen attentively and try to completely grasp what your interlocutor really thinks and feels. Write down the remarks that have been particularly painful for you and let them cause a reaction in yourself. Re-read them until you understand the impression they made on you. Try and identify the situation or the triggering element that creates this undesirable reaction. Do not make objections, even if the feedback seems incorrect.

What can I do with it ? Seaze the opportunity to learn that represents feedback. Take positive feeedback seriously as well. By observing yourself, check the signalled (new) characteristics on the long term. Define a sign with your partner, with which he(she will indicate that your are adopting an inadequate behaviour that was present in the feedback. Develop a strategy to counter the difficulties and develop the qualities at issue. A few months later, ask for a new feedback to exercise.

11. ANNEXES

Tab 1

DSM-IV
Diagnostic and Statistical Manual of Mental Disorders

308.3 Acute Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

1) the person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2) the person's response involved intense fear, helplessness, or horror.

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
2) a reduction in awareness of his or her surroundings
3) derealisation
4) depersonalisation
5) dissociative amnesia

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilising personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance or a general medical condition and...

309.81 Post-traumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

1) the person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2) the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three ..

D. Persistent symptoms of increased arousal (two or more) (difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. Duration of the disturbance (symptoms in Criteria B. C. and D) is more than 1 month.

Specify if:

Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.

Tab 2

ICD - 10
Classification of Mental and Behavioural disorders: Diagnostic criteria for research

F43.0 Acute stress reaction

A transient disorder of significant severity which develops in an individual without any other apparent mental disorder in response to exceptional physical and/or mental stress and **which usually subsides within hours or days**. The stressor may be an overwhelming traumatic experience involving serious threat to security or physical integrity of the individual or of a loved person (e.g. natural catastrophe, accident, battle, criminal assault, rape), or an unusually sudden and threatening change in social position and/or network of the individual, such as multiple bereavement or domestic fire. ...

The symptoms show great variation but typically they include **an initial state of « daze », with some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli, and disorientation**. This state may be followed either by further withdrawal from the surrounding situation, or by agitation and activity (flight reaction or fugue). Autonomic signs of panic (tachycardia, sweating, flushing) are commonly present. The symptoms usually appear within minutes of the impact of the stressing stimulus or event, and disappear within 2-3 days.

Diagnostic guidelines

There must be an immediate and clear temporal connection between the impact of an exceptional stressor and the onset of the symptoms. Onset is usually within a few minutes, if not immediate. In addition, the symptoms:

a) show a mixed and usually changing picture; in addition to the initial state of « daze », depression, anxiety, anger, overactivity, and withdrawal may all be seen, but no one of symptoms predominates for long;
b) **resolve rapidly** (within a few hours at the most) in those cases where removal from stressful environment is possible; in others where the stress continues or cannot by its nature be reversed the **symptoms usually begin to diminish after 24-48 hours and are usually minimal after about 3 days**.

This diagnosis should not be used to cover sudden exacerbation of symptoms in individuals already showing symptoms that cover the criteria of any other psychiatric disorder, except for the personality disorders. However, a history of previous psychiatric disorder does not invalidate the use of this diagnosis.

Includes: - *acute crisis reaction*
- *combat fatigue*
- *crisis state*
- *psychic shock*

F43.1 Post-traumatic stress disorder

This arises as a delayed and/or protracted response to a stressing event or situation (either short- or long-lasting) of an exceptional threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g. natural or man-made disaster, combat, serious accident, witnessing the violent death of others or being the victim of torture, terrorism, rape, or other cruelty).

Typical symptoms include episodes of repeated reliving of the trauma in intrusive memories (« flashbacks ») or dreams, occurring against the persisting background of a sense of « numbness » and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and **avoidance of activities and situations reminiscent of the trauma. Commonly there is fear and avoidance of cues that remind the sufferer of the original trauma**. Rarely, there may be dramatic, acute bursts of fear, panic or aggression, triggered by stimuli arousing a sudden recollection and/or re-enactement of the trauma or of the original reaction to it.

There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. Excessive use of alcohol or drugs may be a complicating factor.

The onset follows the trauma with a latency period that may range from a few weeks to months (but rarely exceeds 6 months). ...

Diagnostic guidelines

This disorder should not generally be diagnosed unless there is evidence that it arose within 6 months of a traumatic event of exceptional severity. A « probable » diagnosis might still be possible if the delay between the event and the onset was longer than 6 months, provided that the clinical manifestations are typical and no alternative identification of the disorder (e.g. as an anxiety or obsessive - compulsive disorder or depressive episode) is plausible. In addition to evidence of trauma, there must be a repetitive, intrusive recollection or re-enactement of the event in memories, daytime imagery, or dreams. Conspicuous emotional detachment, numbing of feeling, and avoidance of stimuli that might arouse recollection of the trauma are often present but are not essential for the diagnosis. The autonomic disturbances, mood disorder, and behavioural abnormalities as well contribute to the diagnosis but are not of prime importance.

The late chronic sequel of devastating stress, i.e. those manifestation decades after the stressful experience, should be classified under F62. ..

Includes: traumatic neurosis

Tab 3

ACUTE STRESS REACTION AND ACUTE STRESS DISORDER

F43.0 Acute stress reaction (ICD-10)

A transient disorder of significant severity which develops in an individual without any other apparent mental disorder in response to exceptional physical and/or mental stress and which usually subsides within hours or days. The stressor may be an overwhelming traumatic experience involving serious threat to security or physical integrity of the individual or of a loved person (e.g. natural catastrophe, accident, battle, criminal assault, rape), or an unusually sudden and threatening change in social position and/or network of the individual, such as multiple bereavement or domestic fire. ...

The symptoms show great variation but typically they include an initial state of « daze », with some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli, and disorientation. This state may be followed either by further withdrawal from the surrounding situation, or by agitation and activity (flight reaction or fugue). Autonomic signs of panic (tachycardia, sweating, flushing) are commonly present. The symptoms usually appear within minutes of the impact of the stressing stimulus or event, and disappear within 2-3 days.

Diagnostic guidelines

There must be an immediate and clear temporal connection between the impact of an exceptional stressor and the onset of the symptoms. Onset is usually within a few minutes, if not immediate. In addition, the symptoms:

a) show a mixed and usually changing picture; in addition to the initial state of « daze », depression, anxiety, anger, overactivity, and withdrawal may all be seen, but no one of the symptoms predominates for long;
b) resolve rapidly (within a few hours at the most) in those cases where removal from stressful environment is possible; in others where the stress continues or cannot by its nature be reversed, the symptoms usually begin to diminish after 24-48 hours and are usually minimal after about 3 days.

This diagnosis should not be used to cover sudden exacerbation of symptoms in individuals already showing symptoms that cover the criteria of any other psychiatric disorder, except for the personality disorders. However, a history of previous psychiatric disorder does not invalidate the use of this diagnosis.

Includes: - *acute crisis reaction*
- *combat fatigue*
- *crisis state*
- *psychic shock*

308.3 Acute Stress Disorder (DSM-IV)

A. The person has been exposed to a traumatic event in which both of the following were present:

1) the person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2) the person's response involved intense fear, helplessness, or horror.

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
2) a reduction in awareness of his or her surroundings
3) derealisation
4) depersonalisation
5) dissociative amnesia

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilising personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance or a general medical condition and ...

Tab 4

POST-TRAUMATIC STRESS DISORDER

F43.1 Post-traumatic Stress Disorder ICD-10

This arises as a delayed and/or protracted response to a stressing event or situation (either short- or long-lasting) of an exceptional threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g. natural or man-made disaster, combat, serious accident, witnessing the violent death of others or being the victim of torture, terrorism, rape, or other cruelty.

Typical symptoms include episodes of repeated reliving of the trauma in intrusive memories (« flashbacks ») or dreams, occurring against the persisting background of a sense of « numbness » and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. Commonly there is fear and avoidance of cues that remind the sufferer of the original trauma. Rarely, there may be dramatic, acute bursts of fear, panic or aggression, triggered by stimuli arousing a sudden recollection and/or re-enactment of the trauma or of the original reaction to it.

There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. Excessive use of alcohol or drugs may be a complicating factor.

The onset follows the trauma with a latency period which may range from a few weeks to months (but rarely exceeds 6 months). ...

Diagnostic guidelines

This disorder should not generally be diagnosed unless there is evidence that it arose within 6 months of a traumatic event of exceptional severity. A « probable » diagnosis might still be possible if the delay between the event and the onset was longer than 6 months, provided that the clinical manifestations are typical and no alternative identification of the disorder (e.g. as an anxiety or obsessive - compulsive disorder or depressive episode) is plausible. In addition to evidence of trauma, there must be a repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagery, or dreams. Conspicuous emotional detachment, numbing of feeling, and avoidance of stimuli that might arouse recollection of the trauma are often present but are not essential for the diagnosis. The autonomic disturbances, mood disorder, and behavioural abnormalities as well contribute to the diagnosis but are not of prime importance.

The late chronic sequelae of devastating stress, i.e. those manifestation decades after the stressful experience, should be classified under F62. ..

Includes: traumatic neurosis

309.81 Post-traumatic Stress Disorder DSM-IV

A. The person has been exposed to a traumatic event in which both of the following were present:

1) the person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2) the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:

- efforts to avoid thoughts, feelings, or conversations associated with the trauma
- efforts to avoid activity places or people that arouse recollection of the trauma
- inability to recall an important aspect of the trauma
- diminished interest or participation in significant activities
- feeling of detachment or estrangement from others
- restricted range of affect (unable to have loving feelings)
- sense of a foreshortened future (loss of expectation)

D. Persistent symptoms of increased arousal (two or more) (difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. Duration of the disturbance (symptoms in Criteria B. C. and D) is more than 1 month.

Specify if:

Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more
With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.

CONTENTS AND OBJECTIVES OF A VERBALISATION ACTIVITY

As noted earlier, the causal factors of the whole reaction to severe stress are based on confusion, emotional overwhelming and powerlessness. In this sense, our method consists of the following: Everything done in the debriefing is supposed to have an effect on these elements. In other words, any action should be meant for and able to diminish at least one of the above elements (confusion, emotional overwhelming, powerlessness) without increasing the others. We can summarise here a certain number of ways that can help overcome the different causal factors of the stress reaction.

CONFUSION	EMOTIONAL OVERWHELMING	POWERLESSNESS
Introduction and presentation of the facilitators and the method.	Physical and psychic protection.	Accompanying the individual to contact and accept the feeling of powerlessness, and admit the ineluctable facts.
Information: about the event, its causes, development and possible effects. Providing technical or organisational understanding.	Security and comfort.	Drive the participants to allow themselves pardon as well as permission to feel and react the way they do.
Descriptions, clarifications and explanations concerning what the participants went through.	Provide a "content" able to welcome with respect, everyone's reactions, thoughts and emotions.	Positive reframing.
Orientation concerning the possible organisational, logistic, administrative or legal procedure.	The process of representation: the intellectual sphere is reactivated (thoughts, comprehension) in order to diminish the overwhelming and to facilitate the integration.	Mobilisation of resources: mobilising the individual and social resources.
Redundancy: repeat information in various ways.	Focusing on sensations and perceptions: operate a truly effective cathartic purpose through a gentle abreaction.	Mobilising the coping capacity and gathering the various coping strategies.
Avoid mixture of different events.	Normalisation of reaction: avoid bringing discredit or over-dramatising the situation.	Allowing a maximum of control and mastery to the individual.
Distinction between various feelings and impressions.	Focus on the representation: using the various necessary media.	Distinguishing the transitional state of victim from a condition of victim as a long-lasting identity.
Reorientation of anger and rage.	Definition of our own security sphere.	Work on assertion and self-positioning.
	Para- and non-verbal support: hypnotic methods.	

10. BIBLIOGRAPHY

Papers

Armstrong, K-R. & coll. (1995) Multiple Stressor Debriefing and the American Red Cross : The East Bay Hills Fire Experience in Social Work Vol. 40 N° 1 : 1-144.

Avery, A. & coll. (1999) Deconstructing psychological debriefing and the emergence of calls for evidence based practice, (Draft) non encore paru.

Allen, S. N. (1994) Psychological assessment of post-traumatic stress disorder. Psychometrics, Curent Trends, and Future Directions, in Psychiatric clinics of North America, vol. 17, No 2.

Barudy, J. (1989) L'utilisation de l'approche systémique lors de thérapies avec des familles de réfugiés politiques dans Thérapie familiale. Vol. 10 N° 1 : 15-31.

Barudy, J. (1992) Migration politique, migration économique : une lecture systémique du processus d'intégraion des familles migrantes dans Santé mentale au Québec XVII : 47-70.

Belfer, R. (1994) Maltraitance En parler, c'est déjà prévenir dans l'Infirmière magazine N° 89.

Bende, B-C. & coll. (1994) North Mersey Community (NHS) Trust - Persistent post-traumatic stress disorder in BMJ Vol. 309 : 526-8.

Bert, C. (1994) Y a-t-il un syndrome de la victime ? Sciences Humaines N° 45.

Berthier, M-L. M.D. & coll. (1998) Reactivation of posttraumatic stress discorder after minor head injury in Depression and Anxiety 8 : 43-47.

Bierens de Haan, B. (1998) Le débriefing émotionnel collectif des intervenants humanitaires : l'expérience du CICR. Schweizer archiv für neurologie und psychiatrie N° 149.

Bisson, J. & coll. (1997) Randomised controlled trial of psychological debriefing for victims of acute burn trauma, in British Journal of Psychiatry, 171, pp 76-81.

Bryant, R-A. & Harvey,A-G. (1995) Acute stress response : a comparison of head injured and non-head injured patients in Psychological Medicine, 25, 869-873.

Bryant, R-A. (1996) Posttraumatic Stress Disorder, Flashbacks, and Pseudomemories in Closed Head Injury, in Journal of Traumatic Stress, Vol. 9, No 3.

Bryant, R-A. & coll. Postconcussive Symptoms and Posttraumatic Stress Disorder after Mils Traumatic Brain Injury, in The journal of Nervous and Mental Desease, Vol. 187, No 5.

Carlier, I. & coll. (1998) Disaster-Related Post-traumatic Stress in Police Offices: a field study of the impact of debriefing, in Stress Medicine, Vol. 14: pp 143-148.

Charney D-S. & coll. (1993) Psychobiologic Mechanisms of Posttraumatic Stress Disorder in Arch Gen Psychiatry. Vol 50.

Chez, N. (1995) Aider les victimes de la violence domestique dans « krankenpflege » Soins Infirmiers N° 4.

Christie, D. (1999) Aux racines de la violence. Campus 43 Uni Genève.

Christie, D. (1999) Les racines de la violence. Angoisse de mort et agressivité : la maltraitance des personnes âgées. Campus 43 Uni Genève.

CICR. (1994) Engagement humanitaire et conflits armés – Le facteur STRESS. Memento.

Cifali, Mi. (1999) Les racines de la violence. Au bout de la violence ? Campus 43 Uni Genève.

Clarke, R-W. & Gray,C. (1994) Options for change in the NHS consultant contract in BMJ Vol. 309 : 528-30.

Correa, A & coll. (1995) Rwanda : quelle prise en charge pour les enfants du génocide ? Pour la Revue de psychiatrie de l'enfant et de l'adolescent.

Crocq, L. (1991) L'inventaire-échelle de névrose traumatique.

Crocq, L. (1992) Panorama des séquelles des traumatismes psychiques. Névroses traumatiques, états de stress post-traumatique et autres séquelles. « Psychologie médicale » N° 24 : 427-432.

Dardel Jaouadi, F. (1992) Du cri au silence. Les mécanismes de défense de l'intervenant in Psychoscope 8.

De Clercq, M. & Coll. (1992) Short and long term psychological and psychiatric consequences of disasters in : JEUR 5. 61-66.

De Clercq, M. (1995) Les répercussions des syndromes de stress post-traumatique sur les familles dans Thérapie familiale Vol. 16 N° 2 : 185-193.

De Clercq, M. & Cassiers, L. (1990) Le travail de la crise à l'épreuve de l'urgence dans Acta psychit. 81-99.

De Clercq, M. (1993) Intervention de crise au service des urgences d'un hôpital général à Bruxelles dans psychologie médicale : 496-500.

De Clercq, M. & coll. (1992) Short and long term psychological and psychiatric consequences of disasters. Jeur 61-66.

Dentan, M-C. (1992) Projet thérapeutique « A chaud » pour les victimes de détournement aérien, de catastrophe ou d'attentat dans Psychologie médicale 24, 5 : 486-489.

Drudi, G. & Paquette, J. (1993) Blessure d'enfant, Violence d'adulte. Service des communications du CSSMM – C.P.E.J. en collaboration avec le B.S.S. Centre-Nord.

Erkohen, M. (1992) Enrayer le mal et apporter la guérison. Le psychologue face aux mauvais traitements in Psychoscope 8.

Everly, G.S. (1995) The role of the critical incident stress debriefing process in disaster counseling, in Journal of mental health counselling, pp. 278-290.

Fabre, J. (1995) Un congrès pour faire échec à la violence dans les soins dans Société & Culture.

Fleury , F. (1994) Famille victime de guerre : approche préventive. Association « appartenances »

Franceschi-Chaix, F. (1993) Le syndrome de Burn-out : étude clinique et implications en psychopathologie du travail dans Recherche en soins infirmiers N° 32 Publication ARSI

Freehill, K-M. MS, RN (1992) Critical incident stress debriefing in health care in Critical care clinics. Vol. 8 N° 3.

Frey, C. (1998) Le traitement des victimes de tortures et des victimes de guerre en exil, in Bulletin des médecins suisses, No 41

Foa, E. B. & co. (1993) Reliability and Validity of a Brief Instrument for assessing PTSD, in Journal of Traumatic Stress, Vol. 6, No 4.

Fried, E. (1987) Violence dans « Vorübungen für Wunder » Wagenbach-Taschenbuch 143.

Friedman, M-J. M.D., Ph.D.(1996) PTSD Diagnosis and Treatment for Mental Health Clinicians in Community Mental Health Journal Vol. 32, N° 2.

Freud, S. (1893) Charcot, in *Standard Edition of the Complete Psychological Works of Sigmund Freud*, vol 3, trans. J. Strachey, Hogarth Press, London, 1962, 19.

Freud, S. (1896) The Aetiology of Hysteria, in *Standard Edition of the Complete Psychological Works of Sigmund Freud*, vol 3, trans. J. Strachey, Hogarth Press, London, 1962, 19.

Freud, S. (1925) An Autobiographical Study", in *Standard Edition*, vol. 20, trans. J. Strachey, Hogarth Press, London, 1959, 34.

Frueh, B-C & coll. (1996) Trauma management therapy : A preliminary evaluation of a multicomponent behavioral treatment for chronic combat-related ptsd in Pergamon Vol 34 N° 7, 533-543.

Gantheret, F. (1980) Regard psychanalytique sur la violence dans Conférence prononcée à l'institut de psychanalyse de Barcelone.

Golden, R.-N. & Coll. (1991) Serotonin, Suicide, and Aggression : Clinical Studies in J Clin Psychiatry N° 52 : 12 (suppl.) : 61-69.

Gravier, V. & coll. (1996) Prévention des séquelles psychiques post-traumatiques Le « debriefing » dans ThéraPSY Vol. 2 N° 3.

Guggenbühl, D. & Coll. (1997) Service sanitaire coordonné. Debriefing. Bulletin d'information sur le SSC en Suisse.

Herzig,. & Muller, C. (1997) Débriefing dans un cadre scolaire par l'équipe jeunesse et santé. Gestion des conséquences d'un assassinat dans une classe d'apprentis, in Revue médicale de la Suisse Romande, vol. 117, pp. 55-59.

Hodgkinson , P. (1988) Transportantion Mass Disaster in Medicine, Science and the Law N° 28 : 304-308.

Horowitz, M. (1979) Impact of Event Scale: A Measure of Subjective Stress, in Psychosomatic Medicine, Vol. 41, No 3.

Hurni, M. & Stoll, G. (1997) Une défense perverse méconnue : l'exportation des conflits intrapsychiques dans la société. Par exemple : une campagne décervelante. Bulletin des médecins.

Irminger, S. (1993) Violence Droit de Réponse - Forum -

Jacobs, B.-L. (1994) Serotonin, Motor Activity and Depression-Related Disorders in American Scientist, Vol. 82 : 456- 463.

Jouan, A. & Belfer, R. (1978) Le monde du silence Face à la violence dans l'infirmière magazine N° 78 : 4-5.

Kérouac, M. (1999) Etudes éricksoniennes et stratégiques d'outils d'aides opérationnels pour la gestion des crises nécessaires à la croissance.

King, N S. (1996) Post- traumatic stress disorder and head injury as a dual diagnosis : « islands » of memory as a mechanism in Journal of Neurology, Neurosurgery, and Psychiatry 1997 ; 62-82.

Kocher, B. & Brechbühler, M. (1995) Situations violentes dans les soins dans « krankenpflege » soins infirmiers N° 4.

Kohlrieser, G. (1985) Violence directe ou larvée dans les situations de soins et de travail. – ESEI Lausanne.

Lagerback, B. (1991) Victimes de crimes et leurs réactions dans Anneau Blanc.

Lebbe-Berrier, P. & coll. (1996) Les Violences sexuelles dans la famille. Modélisations des interventions avec des familles incestueuses dans Thérapie familiale Vol. 17 N° 2 : 295-307.

Leuenberger, J.-F. (1997) Sensibilisation au débriefing dans le contexte scolaire, in Revue médicale de la Suisse Romande, 117.

Lindsay, J. & coll. (1997) Intervention de groupe dans les situations d'urgence et de crise. Cahiers du service social des groupes N° XIV. Faculté des sciences sociales - Université Laval.

Loutan, L.. & coll. Réfugiés de la Violence dans Unité Opérationnelle de Médecine Communautaire Policlinique de Médecine.

Louville, P. Les secours psychologiques post-catastrophe.

Marneffe, C. (1992) The violent family : balancing between support and control, symposium of the World Health organization on »Health Promotion by the family ».

Mc Carthy, J. & coll. (1995) From victim to survivor in Medical Foundation for the Care of Victims of Torture.

Mc Farlane, A-C. (1988) The Longitudinal Course of Posttraumatic Morbidity. The Range of Outcomes and Their Predictors in The Journal of Nervous and Mental Disease. Vol. 176 N° 1

Mc Millan, T.M. (1996) Post-traumatic stress disoeder following minor and severe closed head injury : 10 single cases, in Brain Injury, vo. 10, No 10, pp. 749-758.

Medical foundation. (1996) Lives under threat : a study of Sikhs coming to the UK from the Punjab in medical foundation for the Care of Victims of Torture.

Medical foundation. (1996) Facing persecution at home or destitution in the UK, in Medical Foundation for the Care of Victims of Torture.

Métraux, J.-C. (1997) Aux temps de la survie, le droit au silence, in Revue Médicale de la Suisse Romande, 117, 419-423

Mitchell, J.T. (1983) When disaster Strikes, in Journal of Emergency medical Sevices, vol. 8 (1).

Mitchell, J.T. (1985) Healing the Helpers, in Green (Ed.) Role Strressors and Supports for Emergency Workers, U.S. Dept. of Health and Human Services, Washington, C.D.

Mitchell, J.T.& Bray, G. (1990) Emergency Services Stress, Brady, Prentice Hall.

Monsour Scurfield, R. & Tice, S-N. (1992) Interventions with Medical and Psychiatric Evacuees and their Families : From Vietnam through the Gulf War in Military Medicine, 157, 2 : 88.

Mouren-Simeoni, M.C. (1994) Actualité du syndrome de stress post-traumatique chez l'enfant, in Ann. Méd.-Psychol., 152, no 10.

Munyandamutsa, N. (1995) Rescapés Rwandais du génocide : coincés entre le monde des vivants et celui des morts : comment les aider à continuer ?

Naitove, Connie E. (1978) Arthérapie avec les enfants victimes d'exploitation sexuelle – Commision de la Maison-Blanche sur la Santé Mentale.

Norris, F.H. (2001) 50'000 Disaster Victims Speak : An Empirical Review of the Empirical Literature, 1981-2001. The National Center for PTSD.

Nurse, D. (1996) Le stress post-traumatiique. Une politique pour en atténuer les répercussions, in La Gazette de la GRC, vol. 58 (5), pp. 2-5.

Ohry, A. & coll. (1996) Post-traumatic stress disorder in brain injury patients, in Brain Injury, vol. 10, N0 9, pp. 687-695.

Oligny, M. (1990) Stress et burnout en milieu policier. Presses de l'Université du Québec.

Pauly, V. & Regat, M. (1993) Agressivité, violences et conflits dans les blocs opératoires. Inter Bloc N° 3 : 93.

Perret, F. (1999) Société Agressions. La vague des cambrioleurs-boxeurs. L'HEBDO N° 11.

Perret-Catipovic, M. Journée Santé des Migrants : famille, migration et violence. L'adolescent migrant.

Peter, D. (1998) Plan ORCA – Vaud : Prévention et gestion du stress traumatique. 3ème Journée Romande de la chaîne de sauvetage sanitaire – Gollion 1998.

Ragaisis, K.M. (1994) Critical incident stress debriefing : a family nursing intervention, in Archives of Psychiatric Nursing, vol. 7 (1), pp. 38-43.

Ragsdale, K-G. & coll. (1996) Effectiveness of Short-Term Specialized Inpatient Treatment for War-Related Posttraumatic Stress Disorder : A Role for Adventure-Based Counseling and Psychodrama in Journal of Traumatic Stress, Vol. 9, N° 2.

Ratey, J-J 1 Gordon, A. (1993) The Psychopharmacology of Aggression : Toward a New Day in Psychopharmacology Bulletin N° 29 : 65-73.

Rose, S. & Bisson, J. (1998) Brief Early Psychological Interventions Following Trauma : A Systematic Review of the Literature, in Jornal of Traumatic Stress, Vol. 11, No 4.

Ribaux, O. (1999) Société « Le recours à la violence reste une exception » L'HEBDO N° 11.

Ruff, R.M. & coll. (1996) Miserable minority : emotional risk factor that influence the outcome of a mild traumatic brain injury, in Brain Injury, vol. 10, No 8, pp. 551-565.

Ruzek, J. & coll. (2001) Early intervention to prevent PTSD and other trauma-related problems, in PTSD Research Quaterly, The National Center for Post-Traumatic Stress Disorder, vol 12, No 4.

Saari, S. (1995) How to raise the profile of psychologists in public : Psychological work in major disasters in News from EFPPA.

Sbordone R.J. & coll. (1995) Mild traumatic brain injury does not produce post-traumatic stress disorder, in Brain Injury, vol. 9, No 4, pp. 405-412.

Schreiber, S. (1995) Migration, traumatic bereavement and transcultural aspects of psychological healing : Loss and grief of a refugee woman from Begameder County in Ethiopia in British Journal of Medical Psychology 68 : 135-142.

Scurfield, R.M. (1992) Interventions with medical and psychiatric evacuees and their families : from Vietnam through the Gulf War, in Military Medicine, vol. 157 (2), pp. 88-97.

Shapiro, F. (1988) Efficacy of the Eye Movement Desensitization Procedure in Treatment of Traumaic Memories in Plenum Publishing Corporation.

Shapiro, F. (1989) Eye movement desensitization : a new treatment for post-traumatic stress disorder in Ther. & Exp. Psychiat . Vol. 20 N° 3 : 211-217.

Shore, J-H & coll. (1986) Psychiatric Reactions to Disaster : The Mount St. Helens Experience in Am J Psychiatry 143 : 5.

Sloan, I-H. & coll.(1994) A Shooting Incident in an Elemenary School : Effects of Worker Stress on Public Safety, Mental Health, and Medical Personnel in Journal of Traumatic Stress Vol. 7 N° 4.

Smaga, D. & Coll. (1995) Les états de stress post-traumatique (PTSD) en médecine dans Méd. & Hyg. N° 53 : 936-42.

Sudhakar Madakasira & O'Brien, K-F. (1987) Acute Posttromatic Stress Disorder in Victims of a Natural Disaster in The Journal of Nervous and Mental Disease. Vol. 175 N° 5.

Torracinta, C. (1999) Violences et télévision II : l'avis d'un journaliste. Entretien Campus 43 Uni Genève.

Treyer, C. & Kohlrieser, G-A. (1995) La violence : miroir de soi, miroir de l'autre dans krankenpflege – soins infirmiers N° 4.

Trocmé, N. (1993) L' infirmière confrontée à la violence dans Soins et Société - Soins formation - Pédagogie - Encadrement N° 7 : 54-60.

Van der Linden, M. (2000) Des souvenirs récupérés, oubliés ou faux, les divers troubles de la mémoire autobiographique, in Psychoscope, vol. 21, 8/2000.

van der Kolk, Bessel (2000) Posttraumatic stress disorder and the nature of trauma in *Dialogues in clinical neuroscience*, vol. 2 No 1

Vedantham Kumar & coll. (2000) Neurobiological findings in posttraumatic stress disorder : a review in *Dialogues in clinical neuroscience*, vol. 2 No 1

Villard F. (1996) Rapport sur la visite des services de sûreté de l'aéroport de Londres-Heathrow du 03.10.1996 rédigé à l'Aéroport International de Genève Service de Sécurité.

Villerbu, L.M. & Coll. (1990) La violence au risque du travail social dans Les cahiers de Cliniques Psychologiques N° 7. Conférences

Von Overbeck, S. La valeur traumatique de la migration et ses conséquences cliniques.

Von Overbeck, S. Le travail avec les migrants victimes de traumatismes.

Waters, J. & Jaffurs, W. (1991) Critical Incident Stress Debriefing for Emergency Service personnel in North Carolina, in NCMJ, vol. 52 (12), pp. 641-643).

Watson, Ch.-G. & coll. (1991) The PTSD intervew : rationale, description, reliability, and concurrent validity of a DSM-III based technique, in Journal of Clinical Psychology, Vol. 47, No 2.

Weaver, J. (1999) How to assist in the aftermath of disasters and other life crises, in Innovations in Clinical Practice : A Source Book, Vol 17.

Weerts Withmore, E-A. & Coll. (1993) The association between punitive childhood experiences and hyperactivity in Child Abuse & Negiect. Vol. 17 : 357-366.

Windisch, U. (1999) Médias, violences et sciences sociales, L' Age d'Homme. Entretien Campus 43 Uni Genève.

Yehuda, R. & Mc Farlane AC (1995) Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. in Am j Psychiatry, 152: 1705-1713

Books

ALEXANDER, CH. (1995) La petite fille du silence. Fixot, Paris.

ANGEL, P. et coll. (2005) Développer le bien-être au travail, Dunod ed., Paris.

ANGE RAOULT, P. (sous la dir. de)(1999) Souffrance et violence : psychopathologie des contextes familiaux, l'Harmattan, Paris.

ANZIEU, D. et coll.: (1985) Mélanie Klein aujourd'hui, Césura Lyon Edition.

AUDET, J. & KATZ, J.-F. (1999) Précis de victimologie générale, Dunod, Paris.

BAECHLER, J.: (1975) Les suicides, Ed. Calmann-Lévy, Paris.

BARUDI, J.(1977) La douleur invisible de l'enfant, Approche éco-systémique de la maltraitance, Ed. érès, Ramonville.

BERGERET, J.(1972) Psychologie pathologique, Masson, Paris.

BERGERET, J.(1975) La dépression et les états limites, Payot, Paris.

BERGERET, J.(1985) La personnalité normale et pathologique, Dunod, Paris.

BERGERET, J. (1996) La violence fondamentale, Dunod, Paris.

BERN, E. (1966) Games People Play, the Psychology of Human Relationships. André Deutsch Limited, Londres.

BRYANT, R. et HARVEY, A. (1999) Acute Stress Disorder. A handbook of theory, assessment and treatment. American Psychological Association, Washington DC.

CHALVIN, D.: (1984) L'affirmation de soi, Ed. ESF, Paris, 94 p.

CHAPELIER, J.-B. & PRIVAT, P. (sous la dir. de) (1999) Violence, agressivité et groupe, Ed. érès, Romonville.

CHAUVENET, A., DESPRET, V., LEMAIRE, J-M. (1996) Clinique de la reconstruction, l'Harmattan, Paris.

CHENEVERT, M. (1980) Techniques spécialisées d'entraînement à l'affirmation de soi à l'usage des professionnels de la santé, Ed. Edisem, Québec, 142 p.

CIRILLO, S. DI BLASIO, P.: (1989) La famille maltraitante, ESF, Paris.

CIAVALDINI, A. (1999) Psychopathologie des agresseurs sexuels, Masson, Paris.

COTINAUD, O.: (1983) Psychologie et soins infirmiers, Approche relationnelle, (Coll. infirmières d'aujourd'hui) Ed. Le Centurion, Paris, 299 p.

CROCQ, L. (1999) Les traumatismes psychiques de guerre, Ed. Odile Jacob, Paris.

CYRULNIK, B. (1999) Un merveilleux malheur, Ed. Odile Jacob, Paris.

CYRULNIK, B. (2001) Les vilains petits canards, Ed. Odile Jacob, Paris.

De CLERCQ, M. et LEBIGOT, F. (2001) Les traumatismes psychiques, Masson, Paris.

De SOIR, E. ((2004) Marqué au cœur. Le trauma des équipes de secours, Garant ed., Avers-Apeldoorn.

De SOIR, E., DAUBECHIES, F. & Van Den STEENE (2007) Stress et trauma en milieu policier, Maklu, Anvers-Aperdoorn.

FERENCZI, S. (1968) Psychanalyse I, II et III, oeuvres complètes, Payot, Paris.

FOA, E., KEANE, T. ET FRIEDMAN, J. (2000) Effective Treatments for PTSD. The Guilford Press, New York.

GABEL, M. , LEBOVICI, S., MAZET, PH.(1995) Maltraitance: maintien du lien, Ed. Fleurus psychopédagogie.

GIRDANO, D., DUSEK, D. et coll. (1997) Controlling stress and tension,(7eme ed), Pearson, San Francisco,

GOLEMAN, D. (1997)L'intelligence émotionnelle, Robert Laffont, Paris.

GOSSELIN, G. (1992) La pédophilie, analyse psychanalytique de la structure perverse, EMPC, Montignies-sur-Sambre.

GRINKER, R. & SPIEGEL, J (1945) : Men Under Stress, Blakeston, Philadelphia.

GUTTON, PH. & MARTY, F. (1998) Violence, Revue Adolescence, tome 16 – No 1, Ed. Greupp, Paris.

HALPERIN, D., BOUVIER P. & REY WICHY H. (sous la dir. de).(1997) A contre-cœur, à contre-corps. Editions Médecine et Hygiène. Genève.

HANUS, M. (2001) La résilience à quel prix ? Survivre & rebondir. Maloine, Paris.

HEDIGER, H.(1961) The Evolution of Territorial Behavior" in S.L. Washburn "Social Life of Early Man" New York, Viking Fund, Publication in Anthropology No. 31.

HERMAN, J. (1992) Trauma and Recovery, Basic Books, New York.

HIRIGOYEN, M.-F. (1998) Le harcèlement moral. La violence au quotidien, Syros, Paris.

HIRIGOYEN, M.-F. (2001) Malaise dans le travail, Harcèlement Moral. Démêler le vrai du faux. Syros, Paris.

Histoire de violence, La lettre du Grapp,(1999) No 38, Ed. érès, Ramonville.

JUFFE, M. (1999) La Tragédie en héritage, de Freud à Sophocle. Ed. Eshel, Paris.

KARDINER, A. & SPIEGEL, H. (1947) : War, Stress, and Neurotic Illness, Hoeber, New York.

KLEIN, M., RIVIERE, J. (1984) L'amour et la haine, (Coll. Sciences de l'homme) No. 112, Ed. Petite bibliothèque, Payot, Paris.

Les traumatismes psychiques. (1993) Le bloc-notes de la psychanalyse, no. 12, George, Genève.

LABORIT, H. (1976) Eloge de la fuite, Robert Laffont, Paris.

LARIVEY, M. (2002) La puissance des émotions, Les Editions de l'Homme, Quebec.

LAZARUS, R.S. (2006) Stress and Emotion, Springler Publishing Compagny, New York.

LORENZ, K.: (1969) L'agression, Flammarion, Paris.

MANCIAUX, M. (2001) La résilience, résister et se construire, Ed Médecine et Hygiène, Genève.

MELTZER, D. (1987) Le développement kleinien de la psychanalyse, Privat, Toulouse.

MILLER, A.(1984) C'est pour ton bien, Racines de la violence dans l'éducation de l'enfant, Ed. Aubier Montaigne, Paris, 320 p.

MORIN, E.(1979) Le Paradigme perdu : la nature humaine, Ed. Seuil, Coll. Point No. 109, Paris.

MUNYANDAMUTSA, N. (2001) Question de sens et des repères dans le traumatisme psychique. Edition Médecine et Hygiène, Genève.

ORNER, R. & SCHNYDER, U. (2003) Reconstructing early intervention after trauma. Innovations in the care of survivors. Oxford University Press, New York.

RAPHAEL, B., WILSON, J. (2000) Psychological Debriefing. Theory, practice and evidence, Cambridge Universitiy Press, Cambridge.

RICHELLE, M. REQUIN, J. et ROBERT. M. (1994) Traité de psychologie expérimentale, Tomes 1 et 2, PUF, Paris.

ROSATTI , P.(sous la dir) (2002) L'expertise médicale. De la décision à propose de quelques diagnostics difficiles, Médecine et Hygiène, Genève.

SIRONI, F. (1999) Bourreaux et victimes, psychologie de la torture, Ed. Odile Jacob, Paris.

SERVANT, D, & PARQUET Ph. J. (1995) Stress, anxiété et pathologies médicales, Ed. Masson, Paris.

SERVANT, D. (2005) Gestion du stress et de l'anxiété, Ed Masson, Paris.

STEWART, I. & JOINES, V. (1991) Manuel d'Analyse Transactionnelle, InterEditions, Paris.

THIBOUTOT, J. (2000) Gestion du stress et travail policier, Modulo ed., Quebec.

THURIN, J-M. & BAUMANN, N. (2003) Stress, pathologies et immunité, Flammarion, Paris.

TISSERON, S.: (1998) Du bon visage de la honte, Ramsay, Paris.

Traiter la violence, la lettre du Grapp,(1999) no. 39, Ed. érès, Ramonville.

Traumatismes - Actualités psychosomatiques, (2000), no. 3

VAN DER LINDEN, M. & CESCHI, G. (sous la dir de). (2008) Traité de psychopathologie cognitive. Bases théoriques. Tome I. Solal Editeur, Marseille.

VAN DER LINDEN, M. & CESCHI, G. (sous la dir de). (2008) Traité de psychopathologie cognitive. Etats psychopathologiques. Tome II. Solal Editeur, Marseille.

VAN GIJSEGHEM, H. (sous le dir. de): (1992) L'enfant mis à nu. L'allégation de l'abus sexuel : la recherche de la vérité, Ed. Méridien, Québec.

VAN GIJSEGHEM, H. (1998) La personnalité de l'abuseur sexuel, Ed. Méridien, Québec.

VAN RILLAER, J.: L'agressivité humaine, (Coll, psychologie et sciences humaines) No. 59, Ed. Dessart et Mordaga, Bruxelles, 268 p.

VANOTTI, M. (sous la dir. de) (1992) Le silence comme un cri à l'envers, Ed. Médecine et Hygiène, Genève.

VILA, G; PORCHE, L.M. MOUREN-SIMEONI, M.C.(1999):L'enfant victime d'agression. Etat de Stress post-traumatique chez l'enfant et l'adolescent, Masson Paris.

VILLERBU, L.M. (1992) Violence Délinquance Psychopathie, PUR, Annales Psychologiques Cliniques Rennes.

VITRY, M. (2002) L'écoute des blessures invisibles, L'Harmattan, Paris.

WIDLOCHER, D. (1994) Traité de psychopathologie, PUF, Paris.

The editor :

Michel Berclaz initially trained to be a psychiatric nurse and then a teacher in psychiatric nursing, he is now a psychologist, specialised FSP in psychotherapy since1995.

Former deputy head of the AGPsy-Police intervention unit since its creation in 1996, untill 2007. He also participates in the elaboration, organisation and teaching in various programmes concerning psychological support, emergency intervention and therapy to victims.

Michel Berclaz
Psychologue spécialiste FSP en psychothérapie
Rue des Eaux-Vives, 94
CH – 1207 Genève
☎ 0041 22 736 41 90 E-mail prof : m.berclaz@bluewin.ch site web : www.psyurgence.ch

Grazia Ceschi Phd : Professor at the Cognitive Psychopathotoly and Neuropsychology Unit. University of Geneva, Geneva, Switzerland

grazia.ceschi@unige.ch

http://www.unige.ch/fapse/upnc/Cognitive_Psychopathology_and_Neuropsychology_Unit.htm#Grazia

Christophe Grandjean, child psychiatrist, practises in an outpatient consultancy since 1993 in the north of the Vaud canton (Switzerland), he also works as a consultant and liaison officer in the education sector.

His past experience has led him to be particularly aware of the situation of children disturbed by critical incidents, which in turn led him to specialise in emergency psychological interventions. He contributed to the organisation of the crisis cells in schools in his region.

In collaboration with :

Raymond Lafond : expert-counsellor in emergency social service, Office of Emergency Services, Planning and Emergency Intervention Centre, Health Canada, who kindly assisted by providing us with his article on global intervention in situations of catastrophe.

Maurice Gardiol : chaplain of the Reformed Church of Geneva. Coordinator of the spiritual support team.

Annik Duret : psychologist specialised FSP in psychotherapy. deputy head of the AGPsy-Police intervention unit from 2007 to 2009. She teaches psychological support, emergency intervention and therapy to victims in various programmes.

Cédric d'Epagnier : psychologist specialised FSP in psychotherapy. Member of both AGPsy-Police and Gipsy intervention units, he teaches psychological support, emergency intervention and therapy to victims in various programmes.

Fabienne Naef, psychologue travaillant au service psychologique de la police genevoise et formatrice en AT, pour leurs apports dans le sous-chapitre traitant de la thérapie brève.