# HEALTH AT YOUR UNIVERSITY

## Mental health

In collaboration with UNAFAM

Educate yourself about psychiatric disorders and their common misconceptions

We help you to know more about eating disorders

## Fighting against sexual and sexist violence

In collaboration with nous toutes .org Brest

Learn how to deal with street harassment and GHB intoxication

**Get informed while having fun with tests, scenarios, games and lots of useful resources!**

## Disability

Check your knowledge about disability and its stereotypes

## Sexual and love life

Review the basics of consent

Discover the vocabulary of STIs and how to avoid them

FAGE LES ASSOS ÉTUDIANTES

Fédé B LE RÉSEAU DES ASSOS - ROUEDAD AR C'HEVEDIGEZHIOU

**Prevention and Health Promotion**

# Do you know the Fédé B?

The Fédé B, for Fédération des associations étudiantes de Bretagne occidentale, is a student association that has been animating your campus and defending your rights and interests for over 25 years!

It is the leading student organization in Brittany, due to the size of its network, its level of representation and the scope of its projects (Pétarades, AGORAé,...).

You can find it in Brest, Quimper and Saint-Brieuc.


fedeb.net

@fedeb.net

contact@fedeb.net

@fedebzh

02 98 01 29 36

6 Avenue Victor le Gorgeu
29238 Brest


FAGE
LES ASSOS ÉTUDIANTES

Fédé B
LE RÉSEAU DES ASSOS - ROUEDAD AR C'HEVREDIGEZHIOÙ

# Summary

# WHAT TO DO AS A WITNESS TO SEXUAL AND SEXIST VIOLENCE?

nous toutes .org Brest

Sexist and sexual violence is a reality, especially in France where **94,000 women** are victims of rape or attempted rape each year, **553,000 sexual assaults** are committed each year, **1 woman in 2** has already been sexually assaulted...(1) Similarly, in the world: **80% of women** have already been victims of sexual harassment in public places. (2)

Let's look at two situations related to sexual and sexist violence. Read the different situations below and choose the appropriate behavior(s)!

## SITUATION 1

### PART ONE

It's 10.30 pm, you go to meet some friends in a bar. You walk down the street, a woman is walking on the opposite pavement. At the corner of a building, you see a man approaching you. He comes up to you and asks you if you have a lighter. You answer that you don't smoke, so he decides to ask the woman across the street the same question. Because of the distance between you, you can't hear what she answers. However, the man stays close to her and seems to whisper things in her ear. He is walking right behind her now.

What do you do?

**A** Since there is no physical aggression, I figure it's not a big deal. I walk past them.

**B** Considering their proximity, I wonder if they know each other. After all, I can't hear their conversation... I walk past them by taking a parallel street.

**C** This man's behavior does not seem right and worries me. I try to do something about it.

**D** I notice in the distance another person walking on the same pavement as them and coming towards them: I'll let this person handle the situation.

# SITUATION 1

## PART TWO

You think the situation is street harassment. You decide to act to help this woman.
What do you do?

**A** I walk towards the woman and ask her for directions. My presence seems to have bothered the man, who eventually moves away from us and goes on his way.

**B** I walk over to the person walking on the same pavement as the woman, and ask them to help me intervene.

**C** I decide to discreetly record the incident for a few seconds. Then I go to the man and tell him that I have recorded it and that I could report him.

**D** I keep walking on the opposite pavement. A few minutes pass and the man finally leaves. I walk up to the woman and ask her if she is alright.

**E** I go to the man and tell him that what he is doing is inappropriate and that he must stop immediately.

References

1 Manuel d'action #NousToutes : En finir avec les violences sexistes et sexuelles, Caroline de Haas

2 Survey conducted by L'Oréal Paris and Ipsos in March 2021 in 15 countries: International Survey on Sexual Harassment in Public Spaces

**Correction p. 42**

# SITUATION 2

## PART ONE

The evening is in full swing and you decide to go out to a club with a friend after having a drink at her place. You enter the club, dance a little and then decide to get a drink. Sitting on the bar stools, you talk while holding your drinks in your hands. You wait for your friend to finish her drink before going to the toilet. There are a lot of people in front of you, so you don't come out of the toilet until fifteen minutes later. You look for your friend but don't find her immediately: she is dancing with strangers and seems to be completely drunk. You join her but can't really relate to her mood: she's already very euphoric, pushing people around while dancing and when you ask her if everything is alright, she struggles to be clear. It's strange, she's only had two drinks...
What do you do?

**A** She must not have eaten enough before going out: the alcohol just went to her head quickly. I don't need to worry any further.

**B** She doesn't seem to be in any immediate danger since I'm with her and I'm not drunk. Moreover there doesn't seem to be any potential aggressors around her. I'm going to keep a closer eye on her anyway.

**C** I've never seen her get drunk so quickly: it's weird. I bring her with me to sit in a corner of the club and try to get a better idea of her condition.

**D** I find her condition very strange. To be more reassured, I take us out of the club.

# SITUATION 2

## PART TWO

You have finally decided to leave the club with your friend. Her condition seems to be deteriorating rapidly, to the point where she can't stand on her legs and is very nauseous. She manages to articulate that she just wants to go home to sleep, that you can leave her: she will call a taxi.
What do you do?

**A** I am worried about her increasing nausea: I try to make her throw up, then call a taxi to take her home.

**B** I immediately call the emergency services and stay by her side.

**C** I call a taxi and spend the night at her house to monitor her condition.

**D** As I don't live far away, I carry her home and spend the night with her to monitor her condition.

**Correction p. 45**

# RESOURCES

To find support or ask questions, you can contact **anonymously and for free**:

## Phone

- DROGUES INFOS SERVICES (Drug support helpline): 0 800 23 13 13 — 7 days a week, 8am-2am
- VIOLS FEMMES INFORMATIONS (Raped women support helpline): 0 800 05 95 95 — Mond-Friday, 10am-7pm
- VIOLENCES FEMMES INFOS (Violence against women support helpline): 3919 — 24/7

Video call and sign language translation available with the Rogervoice smartphone application or via the phone icon at the bottom of the website

## Chat

- LA POLICE NATIONALE (The police): service-public.fr — 24/7
- ASSOCIATION "EN AVANT TOUTE(S)": commentonsaime.fr — 7 days a week, 10am-9pm

## Apps

- THE SORORITY: jointhesorority.com

App to fight against domestic violence and all forms of harassment against women and gender minorities, thanks to the network of users ready to help, support and intervene anywhere, anytime.

- APP-ELLES: app-elles.fr

App that allows you to quickly alert and contact your loved ones, emergency services, associations and all the help available around you, in case of emergency, distress or danger.
Real-time audio and GPS tracking, recordings and help resources.

## Social networks

- SAFEWALK FOR ALL BREST: private Facebook group

The aim of this collective, which is open to all, is to group together trips in the city, both day and night, in order to reduce the feeling of insecurity in Brest and to fight against street harassment and aggression.

- SAFEWALKFRANCE: Instagram account

Official and national Instagram account of the collective.

- HÉRO.ÏNE 95: Instagram account

Feminist collective against sexual and sexist violence that communicates a lot about GHB intoxication in the nightlife environment.

- NOUSTOUTESORG: Instagram account

Official Instagram account of the association #NousToutes, which fights against sexual and sexist violence in France.

- NOUSTOUTESBREST/ NOUSTOUTES29QUIMPER / NOUSTOUTES_22: Instagram accounts

Local collectives of the association #NousToutes, which fights against sexual and sexist violence specifically in Brest, Quimper and Saint-Brieuc.

- TYSAFE_ASSO: Instagram account

Association against sexual harassment and violence in public places in Brest Métropole.

nous toutes .org Brest

# RESOURCES

#NousToutes is a feminist collective open to all.
It is composed of activists whose goal is to put an end to the sexist and sexual violence of which women and children are massively victims in France.

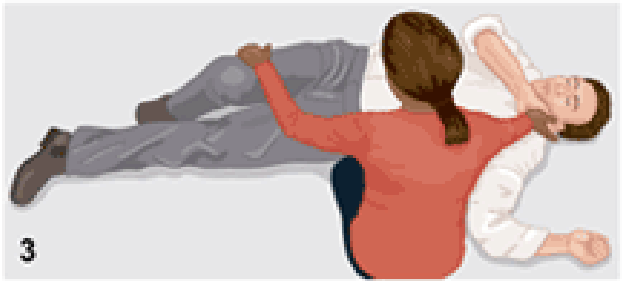
**6 key phrases to support a victim**

1. I believe you (to limit isolation)
2. You were right to tell me about it (to regain self-esteem)
3. It's not your fault
4. He is the offender (to put the guilt back in the right place)
5. The law forbids it
6. I'll help you

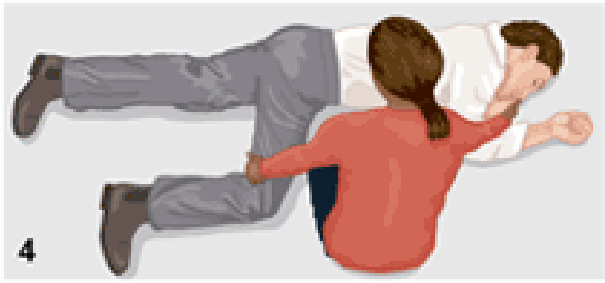
## How to put someone in the recovery position : 4 steps


Place the arm closest to you at right angles to the casualty's body, with elbow bent and palm facing up.


Cross the other arm over the casualty's body and hold the back of his hand against his cheek nearest to you.




Grasp the far leg above the knee and pull it up so the knee is bent.




Pull the leg towards you so the casualty is now lying on his side facing towards you. Make sure the casualty's airway is open and check his breathing regularly until emergency help arrives.

# INVISIBLE DISABILITIES

Disability is said to be invisible when it is not recognised as such by others. It is not visible at first sight, as it can be the case with a motor disability and its wheelchair, for example. Invisible disabilities are therefore most often not identified properly by most people, who do not immediately understand the difficulties the disabled person has with tasks that are considered simple.

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| D | H | B | G | E | H | U | U | Q | V | O | Q | D | F | H |
| Y | E | A | S | Y | Y | P | L | L | Y | T | I | E | D | B |
| S | M | O | O | S | K | X | O | T | C | S | D | P | Y | F |
| P | O | G | Z | A | G | G | T | E | E | A | C | R | S | V |
| H | P | H | R | B | E | B | K | B | E | N | A | E | L | J |
| A | H | D | I | A | B | E | T | E | S | O | N | S | E | E |
| S | I | N | M | X | A | M | L | S | L | S | C | S | X | P |
| I | L | C | S | K | Y | S | G | V | U | M | E | I | I | I |
| A | I | D | E | A | F | N | E | S | S | I | R | O | A | L |
| X | A | V | U | L | U | P | U | S | J | A | R | N | Z | E |
| F | I | B | R | O | M | Y | A | L | G | I | A | V | V | P |
| M | C | Y | S | T | I | C | F | I | B | R | O | S | I | S |
| C | O | L | O | R | B | L | I | N | D | N | E | S | S | Y |
| S | G | V | W | H | D | Y | S | P | R | A | X | I | A | S |
| S | C | H | I | Z | O | P | H | R | E | N | I | A | I | V |

## Find 16 invisible disabilities hidden in the game:

- Chronic and/or disabling diseases
  **diabetes, cancer, MS (multiple sclerosis), epilepsy, cystic fibrosis, hemophilia, fibromyalgia, lupus**
- Cognitive disorders
  **dyslexia, dyspraxia, dysphasia**
- Psychiatric disabilities
  **depression, schizophrenia**
- Sensory disabilities
  **deafness, anosmia, color blindness**

**Correction p. 48**

# TRUE / FALSE

1. The origin of the word "handicap" comes from the name of Professor Andy Kapp, an Austrian psychiatrist known for his description of mental deficiencies.

2. The percentage of invisible disabilities is 50%.

3. The percentage of disabilities diagnosed at birth is 60%.

4. Few disabilities are visible at all times.

5. On 11 February 2005, the law for equal rights and opportunities, participation and citizenship of disabled people was created in France.

6. A departmental center for the disabled (MDPH) has been set up in each department in France since the law of 11 February 2005.

7. In France, the mandatory quota of disabled workers for companies with more than 20 employees is 15%.

8. A person with a disability who works in France systematically obtains a recognition of the status of disabled worker (RQTH).

9. Dyslexia, dysphasia and dyspraxia are specific cognitive disorders.

10. Anosmia is the partial or complete loss of the sense of smell.

11. Lupus is an STI that becomes disabling in the long term.

12. Fibromyalgia is a chronic condition characterized by persistent diffuse pain.

**Correction p. 47**

# IS IT YES, IS IT NO?

**9 out of 10 people** have been pressured to have sex. **In 88% of the cases**, it happened several times. **2 out of 3 women** experienced non-consensual sex, with or without penetration. **53.2% of people** have experienced non-consensual penetrative sex. (1)

Let's go over the notion of consent together. Read the different situations below and choose the appropriate behavior(s)!

## SITUATION 1

The party is almost over, you are tired and really want to go home. However, the girl you have been flirting with for several months makes a move on you and invites you to go to one of the bedrooms upstairs. She seems to be drunk. What do you do?

**A** I go for it: I know she's really interested in me as we've been flirting for a while now!

**B** I hesitate but finally I figure I can follow her because I'm also a bit drunk.

**C** I refuse her advances, but I will make sure she gets home safely.

**D** As she is very insistent, I kiss her just to calm her down, then take the opportunity to make her go home safely.

## SITUATION 2

In the middle of a sexual activity, you feel that your boyfriend is no longer comfortable. The sex was consensual, though. Moreover, it was he who initiated the sexual activity. What do you do?

**A** I stop everything and ask him if everything is alright, if he needs us to stop.

**B** I'm going all the way through the sexual activity: this is not really the time to discuss these things. There will be plenty of time to talk about it once we've finished.

**C** I keep going for a while, waiting for him to say something. If he still doesn't say anything, I stop and ask him if everything is alright.

**D** I stop everything and ask him if everything is fine, if he needs us to stop. However, I'm a bit disappointed that I didn't go through with the sexual activity.

**Correction p. 49**

# IS IT YES, IS IT NO?

## SITUATION 3

You have just started a relationship. Your partner tells you that they do not want to have sex with you for now. However, you know that they have already had sex with their previous partners. What do you do?

**A** I tell them that I find this behavior strange.

**B** I tell them that I am offended and that if they are not interested in me, they should have said so before!

**C** I tell them that I understand, but that I wish they had told me before we became a couple.

**D** I am a bit surprised but I tell them that I understand. I ask them if they want to discuss it.

## SITUATION 4

At a party you are dancing with a girl you fancy. You notice that she is wearing a rather light and short outfit and that she is dancing with you in an increasingly suggestive way. What do you do?

**A** I liked to dance with her but I feel more and more uncomfortable: I decide to go and meet my friends instead.

**B** I feel that this is the perfect moment to make a move: I put my hands up under her skirt.

**C** I keep on dancing with her, hoping that something will happen between us: we'll see how the evening will go on afterwards!

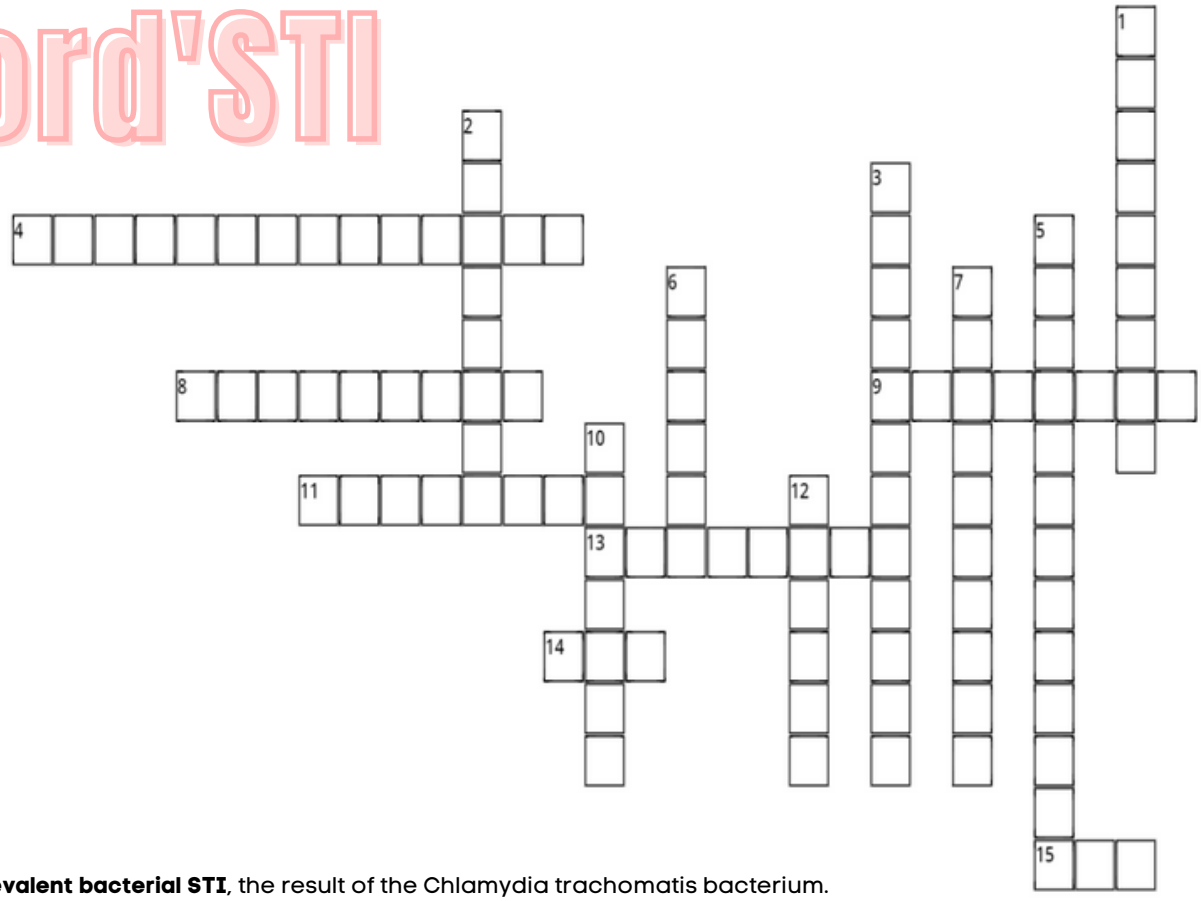
**D** I make a move by asking her if I can kiss her.

## IN A NUTSHELL

The notion of consent is complex and cannot be reduced to "no means no". Consent does not only apply to sexual life (forcing someone to hug them when they do not want to is like ignoring consent). It is therefore necessary to ensure on a daily basis that the people around us are comfortable with such and such behavior, activity, discussion,... For this, we can not repeat it often enough: communication is the key!

1 Manuel d'action #NousToutes : En finir avec les violences sexistes et sexuelles, Caroline de Haas

# CROSS word'STI




## DOWN

**1.** **The most prevalent bacterial STI**, the result of the Chlamydia trachomatis bacterium.
In 2018, people with a uterus aged 15-24 accounted for almost ¾ of cases.
In 60-70% of cases, this infection is silent, otherwise it is likely to cause an infection of the urethra (bladder opening) and cervix (uterus opening).
If the STI is not treated with antibiotics, it can cause infertility in people with a uterus.

**2.** As soon as we learn that we have been infected with an STI, **it is those with whom we have had sex or a risky sexual behavior that we should inform** immediately! This will give them the chance to be treated in time and avoid infecting others.

**3.** **This is what happens when a person with an STI infects another person**. This can happen through unprotected sexual activity, whether through vaginal or anal penetration, mouth-to-sex contact, mouth-to-anus contact or skin-to-skin contact, through blood or through transmission from mother-to-child.

**5.** **This STI is caused by a virus called herpes simplex virus: HSV**. Most of the time, HSV lies dormant and produces no symptoms at all. Therefore, the virus can easily be transmitted sexually without either partner being aware that the carrier has active disease. However, **once contracted, the virus remains in the body and is reactivated periodically.**
This virus mainly affects people with a vagina.
This STI is characterized by the appearance of sores or vessicles on the sexual organs.
Treatment is based on antiviral medication, which can only reduce the duration and intensity of the outbreak. They do not provide a complete cure.

**6.** **It's the main method of preventing STIs** during penetration (it can be internal or external) or during mouth-to-sex and mouth-to-anaus practices (in the form of a dental dam). However, be aware that some STIs require more protection. Indeed, the infected and contaminated areas may not be entirely covered by this protection (in the case of HPV for example). In addition, some STIs can be transmitted through other ways than unprotected sex.

**7.** **This STI is caused by a highly contagious virus (HBV) that is spread through unprotected sex, blood,** but also in rare cases through saliva.
In 80% of cases, this STI is silent. Otherwise, it can cause severe fatigue, nausea, deterioration of general health, and even reach the liver and **cause liver cancer or cirrhosis.**
About 90% of infected people will get rid of it naturally without treatment, before the chronic disease stage. In the case of chronic infection, there are appropriate treatments to inactivate the virus, but complete cure is rare. There is a vaccine for lifelong protection.

**10.** **To ensure that you are not infected with an STI, it is important to do that regularly**, in addition to having protected sex. This can be done in several ways: by taking a blood test, vaginal swab, urethral swab or urine sample. Sometimes the visible symptoms are enough to detect an STI.
It is also important that each partner do that if they no longer wish to use a condom.

**12.** **Do not hesitate to ask them for an STI screening**. Otherwise, it is also possible to make an appointment for free at a free screening center (CeGIDD), a Family Planning and Education Center (CPEF) or a PMI center.

## ACROSS

**4.** **Also known as HPV, this is a family of very common and often benign viruses**. There are over 200 types of this virus.
It is estimated that about 80% of sexually active people will be infected with these viruses in their lifetime.
In most cases, the infection is healed within a few months by natural immunity, without any symptoms. But in 10% of cases, the viruses can persist and are accompanied by the appearance of small genital warts (condylomata acuminata), or even **cancers (especially of the cervix).**
In this case, medication or physical or surgical treatment is necessary. Vaccines against the most common and dangerous types of HPV are also effective.

**8.** **Colloquially known as the clap**, it's a sexually transmitted infection caused by the **bacterium Neisseria gonorrhoeae**. It's likely to cause an infection of the urethra (bladder opening) and cervix (uterus opening).
For people with a vagina, the infection is silent in 70% of cases. Otherwise, it can cause burning or a yellow or greenish discharge with a bad smell from the penis, vagina or anus.
The disease is treated with antibiotics.

**9.** **This STI** is caused by a bacteria called Treponema pallidum and **is transmitted through unprotected sex or blood.**
It is **an old STI** that was first described in 1530.
This STI can be silent and go undiagnosed while the bacteria continue to grow in the body. The course of the disease evolves over time in three stages, the final stage being potentially fatal. The first evidence of the infection is a painless hard, round open sore known as a chancre in the genital area.
This STI can be treated with antibiotics.

**11.** **In order to continue to have it, it is important to be informed about STIs and to be tested** regularly or when having risky sexual behavior.

**13.** **These are the visible and abnormal signs that accompany an STI related infection.** The main visible signs are burning, itching, unusual discharge, abnormal odors, sores, warts or redness in the genital area or anus. Other signs to watch out for include abdominal pain or pain when urinating or having sex.

**14.** **This STI is caused by the Human Immunodeficiency Virus and is spread through unprotected sex and blood. You are said to be hiv-positive when you have the virus and can give the virus to others.**
The main modes of infection for people who discovered their HIV status in France in 2020 were heterosexual sex between cisgender people (53%) and sex between cisgender men (42%).
Infection with the virus has three main phases, the first two of which may not cause many symptoms other than fever, pain and fatigue. However, the virus gradually destroys the body's immune system and lowers its defenses against pathogens until it reaches **the advanced stage of Acquired Immunodeficiency Syndrome (AIDS)**. At this stage, people do not die of AIDS but of opportunistic illnesses that can no longer be treated.
The use of multiple antiretroviral medication now makes it possible to live well with the virus and can even lower the viral load (the amount of virus in the blood) to zero, preventing its transmission. There is also a Post-exposure prophylaxis (PEP) for people who have been exposed to a risk of transmission of the virus, to prevent the infection from occurring. However, this treatment is a last resort and must be started as soon as possible, it means that you must go to the hospital emergency room at best within 4 hours and at the latest within 48 hours after intercourse.

**15.** **Not to be confused with STDs** (Sexually Transmitted Diseases), **they are infections** caused by bacteria, viruses or parasites, **usually transmitted during sexual activities.**
Be aware that these infections often have no visible symptoms, so you can be infected without knowing it and pass them on! Moreover, contracting this type of infection can increase the risk of contracting other infections of the same type.

**Correction p. 50**

# DOSSIER: PSYCHIATRIC DISORDERS

## WHAT IS MENTAL HEALTH?[1]

Mental health is a component of our health as important as physical health. Indeed, the World Health Organization (WHO) defines health as follows: **"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".**
But then, what is mental health? What influences it? To explain it, let's discover the mental cosmos together!

The **mental cosmos** is constituted of several elements:

- **A rocket** (that's us) that flies through the mental cosmos. The rocket's objective is to stay on course, following the milky way of "psychic balance", the one that lets us be happy.

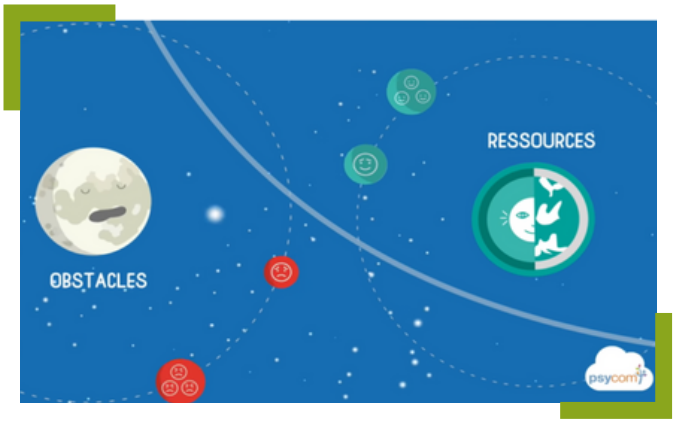
- **Two planetary systems** in permanent motion with their satellites orbiting and feeding them:

→ **The "obstacles" planetary system:** anything that will have a negative influence on our mental health.

→ **The "resources" planetary system:** the resources that will accompany us throughout our lives.

→ **the "individual obstacles" satellite**: what can act negatively on the rocket and which is specific to the individual such as denial, devaluation, withdrawal,...

→ **the "collective obstacles" satellite**: negative influences outside the individual such as exclusion, precariousness, a stressful environment,...




→ **the "individual resources" satellite**: the ability to ask for help, to recognize your feelings,...

→ **the "external factors" satellite**: a caring family environment, easy access to care, recognition by others,...

- **"Accidental occurrences" asteroids** that orbit the rocket and can hit it violently and unpredictably, causing it to deviate from the Milky Way: dismissal, separation, bereavement, war,... If, at the time of the impact, the "obstacles" planet is bigger than the "resources" planet, the rocket will have more difficulty returning to the Milky Way. This explains why two individuals will not react in the same way to the same situation.

- **"Facts" comets** that also orbit the rocket and can collide with it in a violent and unpredictable way: an illness, a disability, a family secret,... But unlike asteroids, which hit the rocket and then continue on their way through the cosmos, comets will cling to the rocket and become a weight to carry for the rest of the journey. It may happen that this comet transforms the rocket by allowing it to develop new skills to cope with this difficulty. This initial burden can then become a strength and reinforce the "resources" planet.

- **"Life events" shooting stars** that regularly cross the rocket and influence it: friendships, professional relationships, love life,... These shooting stars can have a negative or positive influence on the rocket and on the two planetary systems, depending on their nature and the general state of our cosmos.

- **The "red flags" markers** that represent signals that help us measure the thermostat of our mental health and that of others: isolation, sadness, lack of sleep, constant depreciation, risk-taking,... The longer these red flags last and disrupt our daily life, the more they deserve to be listened to. If several of the markers are in the red, it is surely a sign that our mental health deserves special attention. We can then lean on the "resources" planet, in order to find the way back to a satisfactory psychological balance.


**All these factors will therefore influence the size of the two planets and the trajectory of the rocket in the Milky Way. Each person is constantly seeking a balance between the resources they can mobilize to be happy and the obstacles they encounter in their lives.**

1 This section is based on the "kit Cosmos mental® de Psycom"

# DOSSIER: PSYCHIATRIC DISORDERS

## PSYCHIATRIC DISORDERS: WHAT ARE WE TALKING ABOUT?

**DID YOU KNOW?**

**"1 in 5 French people experience a mental disorder at some point in their lives. Young people are on the front line: in over 70% of cases, the first signs appear between the ages of 15 and 25." (1)**

Psychiatric disorders are serious disorders, due to their intensity and frequency. They result from psychiatric pathologies such as schizophrenia, bipolar disorders, major depressive disorders or other disorders, whose manifestations affect a person's life in a lasting way. These disorders manifest themselves in different ways at any age, often starting in the teenage years or as a young adult. It is not always easy to identify and understand what is going on because the manifestations are long-lasting or recurrent: periods of crisis, stabilization and remission may alternate and be unpredictable. The use of drugs or alcohol alone cannot explain these symptoms.
**These disorders have repercussions in all aspects of life and require appropriate support and pharmacological treatment.**

These are warning signs:

→ **Delusions and hallucinations**: Disturb the ability to think, one' s perception of oneself and of reality,...
→ **Disruption of communication, emotions and relationships with others**: Leads to loneliness, withdrawal and anxiety,...
→ **Great difficulty in organizing daily life**: Leads to isolation, marginalization, sometimes negligence,...
→ **Denial of one's condition**: Leads to masking the illness, refusing any medical diagnosis, refusing any medication,...
→ **Misperception of reality, of other people's attitudes:** Leads to hypersensitivity to stress and to the outside world, extreme mood shifts that can change from calm to nervous, maladaptive behavior,...

**Withdrawal, lack of communication, suicidal behavior, distress, distortions in thinking, perception, emotions, language, sense of self and behavior,... are all warning signs.**


**True or False?**
**"Since the law of 11 February 2005, psychiatric disorders are included in the definition of disability."**

True! Psychiatric disability, which is caused by mental disorders, is included in the definition of disability: "For the purposes of this law, any limitation of activity or restriction of participation in society suffered by a person in their environment due to a substantial, lasting or definitive alteration of one or more physical, sensory, mental, cognitive or psychic functions, a multiple disability or a health disorder constitutes a disability;".
Please note: psychiatric disability is different from intellectual disability, which concerns intellectual functioning, and therefore an intellectual deficiency.

1 Fondation fondamentale rapport 2018

# DOSSIER: PSYCHIATRIC DISORDERS

## WHAT ARE THE MOST COMMON PSYCHIATRIC DISORDERS?

## PSYCHOTIC DISORDERS

Psychotic disorder is a general term used to describe a mental health problem that is characterized by a loss of contact with reality. Intense distortions in thinking, feeling and behavior occur.

Psychotic disorders are less common than other psychiatric disorders. Many disorders can be characterized by psychotic episodes, including schizophrenia, psychotic depression, bipolar disorder (which can be characterized by psychotic depressive or manic episodes), schizoaffective disorder and drug-induced psychotic disorders.

**MYTH:** **"Schizophrenia is a split personality disorder."**

**REALITY:** The diagnosis of schizophrenia should not be confused with Dissociative Identity Disorder (DID). **Schizophrenic disorders do not involve a split personality.** It is a disorder that covers a wide range of symptoms from one person to another and for the same person over time, so there is not one type of schizophrenia but several. Schizophrenic disorders can be characterized by distortions in thinking, perception, emotions, language, sense of self and behavior, associated with so-called positive and negative symptoms.

→ **Disorganization of speech** consists of a loosening of the links between ideas, emotions and attitudes. Thinking becomes fuzzy, discontinuous. The person's speech may seem illogical and difficult to follow, their behavior may seem strange and their emotions may appear unrelated to the situation (for example: laughing in a sad situation). The person may also express opposite feelings at the same time.

→ **The so-called positive symptoms** occur "in addition". They are added to the person's usual functioning by modifying their perception of reality: the person sees, hears, smells or feels things that do not exist for those around them, through delusions (for example: the impression that television or radio programmes are addressed directly to them or that their thoughts are guessed or commented on) or hallucinations (for example: sensations of burning or stinging or the person hears voices or sees things).

→ **The so-called negative symptoms** come "as a minus". They take something away from the person's usual functioning. They result in a disinvestment in reality, a gradual social withdrawal, a change in the ability to think, speak and act, a decrease in emotional reactions, and cognitive disorders (difficulties with concentration, attention, memory and abstraction skills).

**600,000 people suffer from schizophrenia in France and 1% of the population worldwide, all cultures and backgrounds combined.** (1)

1 collectif-schizophrenies.com

# DOSSIER: PSYCHIATRIC DISORDERS

**MYTH:** **"People with depressive disorders are lazy and lack the will to get better."**

**REALITY:** Life brings difficulties, conflicts and frustrations that sometimes cause sadness, discouragement and fatigue. These episodes can lead to the mistaken impression of depression. The support of relatives or carers can help to overcome this sadness, this "low mood" without the need for antidepressants. **In major depression**, unlike the " low mood **", mood and feeling of unease vary little from one day to another or according to life events.**
→ Symptoms that may be associated are sadness, withdrawing from loved ones and regular activities, appetite disturbances (with weight loss or gain), sleep disturbances (loss or increase), exhaustion and lethargy or restlessness, loss of self-esteem, feelings of inappropriate guilt, inability to focus, morbid, suicidal thoughts,...
Several of these **symptoms must be present all day and almost every day**, for at least two weeks. They should not appear or disappear depending on life circumstances. Depending on the duration, severity and number of symptoms, we speak of a mild, moderate or severe depressive episode.

**In France, it is estimated that in 2017, 10% of the population aged 18-75 had a major depressive episode, as defined in international classifications. (1)**

**MYTH:** **"People with bipolar disorder change moods all the time: they're fine and within an hour they're really bad."**

**REALITY:** Bipolar disorder is a mood disorder. If left untreated, they are characterized by **alternating phases of excitement known as "manic" or "hypomanic", depressive phases and periods of normal mood.** The intensity, frequency and alternation between these moods vary from one person to another. However, **these periods usually last a few days or weeks, which distinguishes bipolar disorder from mood swings**, which may occur from day to day or several times a day.
→ **The manic episode seems to be the opposite of the depressive episode**: the person may show an expansive mood, increased self-esteem, irritability and will be full of energy for at least four consecutive days. The person may feel the need to talk constantly, be full of ideas, need fewer hours of sleep (for example: feel rested after three hours of sleep) and take risks that they would not normally take. The person may have grandiose ideas and completely lose touch with reality, in other words become psychotic. A less severe manic episode is called a hypomanic episode.

**The WHO ranks bipolar disorders as the 6th most common disability in the world. It affects between 1 and 2.5% of the French population.(2)**

1 Léon C., Chan Chee C., du Roscoät E. ; le groupe Baromètre santé 2017. La dépression en France chez les 18-75 ans : résultats du Baromètre Santé 2017. BEH 2018

2 Fondation fondamentale rapport 2018

# DOSSIER: PSYCHIATRIC DISORDERS

**MYTH:** **"Anxiety problems are only for emotional people."**

**REALITY:** Anxiety is present in all individuals. It is often experienced as unpleasant and occurs in response to danger or a potentially worrying situation. However, it can **become problematic when it becomes too intense or intrusive to the point of disrupting daily life.** This anxiety can then take the form of an anxiety disorder (Generalized Anxiety Disorder (GAD), panic attack or disorder, phobias) or Obsessive Compulsive Disorder (OCD).

→ **Generalized Anxiety Disorder** (GAD) is a **state of persistent anxiety and excessive worry.** This anxiety is not related to a specific object or situation. It is an excessive worrying about everyday moments that the person finds difficult to control. Associated symptoms may be feeling restless, wound-up, or on-edge, hypervigilance (difficulty concentrating, irritability,...) and associated disorders (sweating, nausea, shaking,...).

→ **A panic attack** is an abrupt surge of intense fear or discomfort that reaches a peak within minutes, and during which time a variety of psychological and physical symptoms occur. These attacks may be spontaneous and without apparent cause, or occur in reaction to a traumatic event, intake of toxic substances (alcohol, tobacco, cannabis or other drugs), or may be associated with a physical or psychiatric illness, in connection with the intake or withdrawal of certain medications. The associated symptoms may include rapid heart rate, shaking, shortness of breath, hot flashes, feelings of unreality or detachment from oneself,...

→ **Panic disorder** is the repetition of panic attacks, of spontaneous and unexpected occurrences.

→ **Phobias** are the expression of an unreasonable, intense and specific fear of an animal, object or situation. Phobias are very common, and it is their intensity and impact on the person's life that can make them problematic. Phobias are accompanied by avoidance behaviors of the object or situation, and/or behaviors that reassure. The person is aware of the absurdity of their fear and suffers from it.

→ **Obsessive Compulsive Disorder** (OCD) is manifested by intrusive, repetitive and uncontrollable thoughts, called obsessions, which cause high anxiety. To reduce the resulting suffering, people feel the need to perform certain routines repeatedly, called compulsions, which often involve cleaning, checking things, repeating actions or thoughts, arranging things, counting or seeking reassurance.

**Anxiety disorders affect between 15% and 21.6% of the population in France aged 15 to 85.[1]**

**MYTH:** **"Addictive disorders and psychiatric disorders have nothing to do with each other."**

**REALITY:** Addictive disorders include substance use disorders such as: **alcoholism, drug addiction, smoking, as well as behavioral addictions** (for example: gambling, video games, internet, sex, compulsive shopping,...). The more frequently or in toxic doses a product is used, the more it affects the person. A distinction must be made between dependence (addiction) and harmful use or abuse of a substance.

1 J.-P. Lepine, I. Gasquet, V. Kovess et al, "Prévalence et comorbidité des troubles psychiatriques dans la population générale française : résultats de l'étude épidémiologique", ESEMeD / MHEDEA 2000

Leray E., Camara A., Drapier D., Riou F., Bougeant N., Pelissolo A., Lloyd K.R., Bellamy V., Roelandt J.L., Millet B., "Prevalence, characteristics and comorbidities of anxiety disorders in France : Results from the "Mental Health in General Population" Survey (MHGP)", European Psychiatry 26, 2011

# DOSSIER: PSYCHIATRIC DISORDERS

→ **Addiction** is a set of behavioral, cognitive and physiological phenomena, occurring as a result of repeated use of a psychoactive substance, associated with: a strong desire to take the substance, difficulty in controlling the use, continued use despite the harmful consequences, gradual disinvestment from other daily activities and obligations in favor of the substance, or increased tolerance.
→ **Harmful use** is a pattern of consumption of a psychoactive substance that is damaging to physical and/or psychological health.
The most common addictions are tobacco (nicotine), alcohol and cannabis. **People with psychiatric disorders have a much higher risk of developing addictive disorders**, as many people use alcohol or drugs to relieve their negative emotions. Excessive use or stopping use abruptly can contribute to the development of a psychiatric disorder or exacerbate it. For example, cocaine use can cause an episode of psychotic disorder with paranoia or anxiety.

**The frequency of smoking among schizophrenic patients varies between 60 and 90% of subjects depending on the study, compared to 23 to 30% in the general population.(1)**

***MYTH:*** **"Eating disorders are eating fads."**

***REALITY:*** Eating disorders are not just about food, weight, appearance or willpower: they are serious and potentially life-threatening disorders. They are expressed by **significant disturbances in eating behavior** (under or overeating and/or inappropriate food quality and/or disturbed eating patterns). Eating disorders are often associated with an alteration in the perception of one's appearance, body shape or weight. People with eating disorders may be **underweight, overweight or within the normal weight range.**
→ **Anorexia nervosa** can be defined by voluntary restriction of food, weight loss and the stopping of menstruation (amenorrhoea) for a menstruating person. The person may also experience binge eating.
→ **Bulimia** is characterized by recurrent and frequent episodes of disproportionate food intake accompanied by a feeling of loss of control and followed by behavior to compensate for the excess, for example purging (vomiting, laxatives,...), fasting or excessive exercise.
→ **Binge eating disorder** corresponds to bulimia but without recourse to extreme weight loss strategies to compensate.

**Eating disorders particularly affect women: between 0.5% and 4% of European women are said to be affected by anorexia nervosa, bulimia affects about 6 girls for one boy in the 11-20 age group and binge eating disorder affects about twice as many women as men.(2)**


1 Dervaux A. & Laqueille X., "Tabac & schizophrénie : aspects épidémiologiques et clinique" 2007, L'encéphale, 2008

Keski-Rahkonen, A., & Mustelin, L. (2016). "Epidemiology of eating disorders in Europe : prevalence, incidence, comorbidity, course, consequences, and risk factors". Current opinion in psychiatry

2 ameli-sante.fr : Troubles du comportement alimentaire : anorexie et boulimie, 2016

White A., Kavanagh D., Stallman H., Klein B., Kay-Lambkin F., Proudfoot J., Drennan J., Connor J., Baker A., Hine E., Young R., "Online alcohol interventions : a systematic review.", Journal of Medical Internet Research, 2010

# DOSSIER: PSYCHIATRIC DISORDERS

**MYTH:** **"Trauma and post-traumatic stress disorder are the same thing."**

**REALITY:** Certain events in our lives can produce trauma. **Trauma can be defined as an experience in which our psychic defense capacities are not sufficient**. Events that can cause trauma include among other things: a car accident, a serious illness, witnessing a suicidal act, incest, rape, psychological and/or physical abuse, harassment, an attack,...

In Post-Traumatic Stress Disorder (PTSD), three types of symptoms are often present:

→ **Vivid memories of the event that impose themselves on the person** (flashbacks), nightmares. The person relives the scene, with images, sounds or smells: the physical sensations are intense.

→ **Avoidance of thoughts, situations, people** that could recall the event.

→ **The feeling of a permanent threat**, which may manifest itself in a state of hyper-vigilance, a startle reaction to the slightest unexpected noise.

When these manifestations persist after several weeks and significantly disrupt daily life, it may be a case of Post-Traumatic Stress Disorder. It is never too late to talk about the traumatic events you have experienced and to act on the symptoms of post-traumatic stress.

**True or False?**
**"Only 30% of people with psychiatric disorders have more than one at the same time."**

False! A study conducted in the United States showed that 79% of people with psychiatric disorders had more than one disorder at the same time. It is not uncommon, for example, for a person with an anxiety disorder to also have depression. The terms "dual diagnosis", "comorbidity" and "concomitance" are used to refer to the occurrence of more than one psychiatric disorder in a person. (1)

1 Organisation mondiale de la santé, "Rapport sur la santé dans le monde 2001. La santé mentale : nouvelle conception, nouveaux espoirs", 2011

## WHAT DIFFICULTIES DO PEOPLE WITH PSYCHIATRIC DISORDERS FACE?


**"Stigmatization is the devaluation of a person, it is the fact of labelling a person because of one of their characteristics (skin color, gender, disability,...). Discrimination is the fact of treating a person unfavourably according to a criterion (sex, origin, disability, age,...) and in a specific situation (access to a job, a service, housing,...). In France, as in other countries, discrimination is punishable by law.**

→ **Stigmatization**: Having a psychiatric disorder can be seen by some people as very negative, even degrading. For example, there is a profusion of terms used in **colloquial language** to talk about people with psychiatric disorders: crazy, mental, insane, nuts, loony, deranged,... These terms contribute to the **dissemination of stereotypes** such as "people with psychiatric disorders are dangerous, violent and unreliable", whereas in reality they are more often victims of violence than aggressors. These stereotypes are dehumanizing because they do not provide information about what these people go through and are far from reality. Furthermore, as the disability resulting from a psychiatric disorder is not necessarily visible, these people can also be wrongly considered as weak, lazy, selfish, uncooperative, lacking in willpower, attention-seeking or not really ill.

# DOSSIER: PSYCHIATRIC DISORDERS

Many prejudices about psychiatric disorders are also **spread by the media**, whether in the cinema (for example: schizophrenia in Black Swan or Fight Club is a split personality, psychiatric hospitals are portrayed as prisons for deranged people,...), in TV series or even in press articles and reports, most of which are related to violence. **Moreover, France is among the countries in the world that stigmatize schizophrenia patients the most.** (1)
Stigmatization causes the person who experiences it to suffer. Perhaps even more than the disorder itself, as highlighted in a British study: **"People living with disorders report suffering more from this stigmatization than from the symptoms of the disorder itself".** (2) The stigmatization extends to their relatives and to the world of psychiatry as a whole. Institutions such as psychiatric hospitals, as well as the people who work in them, are poorly regarded by a large part of society. **For 69% of the people interviewed for the Unafam 2021 barometer, their loved one's disorder is portrayed in a stigmatizing and anxiety-provoking way in the media.**

→ **Self-stigmatization**: People with psychiatric disorders may **integrate the stigmatization and discrimination they experience**, beginning to believe the negative comments they hear about themselves and leading to low self-esteem. It can also make them feel that they are no longer a person in their own right, defining themselves only through their disorder.
Self-stigmatization leads the person to limit themselves in activities that are important to them. For example, they may not apply for a job even though they have the necessary qualifications, believing that others are much more competent for the position. Researcher Stephanie Park has identified many consequences of this phenomenon: social isolation, withdrawal and inhibition (high shyness), self-deprecation, feelings of shame, guilt, the constant expectation of being left out and rejected, loss of hope for a recovery,... (3)

→ **Delayed diagnosis**: According to the WHO, the majority of psychiatric disorders appear between the ages of 15 and 25.(4) As a result, when psychiatric disorders appear at this time of life, they can affect young adults' education, their entry into the working life, their ability to establish essential social relationships, including love life, and the formation of habits such as alcohol and other drug use. This is why **it is crucial to identify problems early and ensure that the person gets the care and support they need.** Moreover, the longer a person takes to get help and support, the more difficult the recovery process can be.
Yet for many people, there can be a long period between the onset of psychiatric disorder and the time when they receive appropriate care and support. **For 90% of the respondents to the Unafam 2021 barometer, it took one or more crises (72%) for a diagnosis to be made.** Even more worrying, for more than 2/3 of them, despite medical care, no diagnosis was made.

Thus, in France, only 32.6% of people with psychiatric disorders have received professional help.(5) Stigmatization and self-stigmatization, lack of knowledge of psychiatric disorders and their treatment, lack of human and financial resources (mental health research in France receives only 4.1% of the budget allocated to health research (6) ), and the impairment of reasoning faculties and rational decision-making processes in the context of certain psychiatric disorders are all factors that explain this delay in diagnosis.

1 Etude internationale Thornicroft, Lancet 2009 avec la WPA (Fédération Mondiale de la Psychiatrie); La France se situe parmi les pays plus stigmatisants des 27 étudiés, loin derrière tous les grands pays européens
2 Qualitative analysis of mental health service users' reported experiences of discrimination, 2016
3 Internalized stigma in schizophrenia: relations with dysfunctional attitudes, symptoms, and quality of life, 2013
4 Organisation mondiale de la santé, "La santé mentale : renforcer notre action", Aide mémoire, n°220, septembre 2010
5 Caisse nationale d'assurance maladie, "La "Cartographie", Une analyse médicalisée des dépenses remboursées par l'assurance maladie sur la période 2012-2016", version juillet 2018
6 Etude FondaMental – URC-Eco "ROAMER : A Roadmap for Mental Health Research in Europe"

# DOSSIER: PSYCHIATRIC DISORDERS

→ **Social isolation**: Rejection by society, family or friends, often due to a lack of knowledge about psychiatric disorders. Moreover, daily micro-aggressions, in other words, a repetition of remarks or comments that are meant to be insignificant (for example: calling someone a schizo, a bipo, saying that someone is depressed just because they are sad for a day, using the term "escape" to talk about an unauthorized exit from a psychiatric hospital,...), constantly remind the person that they are outside the norm and/or that their experience is not valid. Self-stigmatization can also lead to withdrawal by people with psychiatric disorders.

→ **The refusal of access to a service** (for example: refusal to register in a sports club), **a right** (for example: refusal to exercise the right to vote while in hospital), or **a good** (for example: refusal to buy a house or take out a bank loan).

→ **Difficulty in employment**: In France, psychiatric disorders are one of the leading causes of disability and work stoppage. **Moreover, less than 20% of people living with a psychiatric disorder are currently working.** [1] However, improvements in treatment and quality of life allow a large number of people to work in the regular workplace. This difficulty in accessing employment is mainly due to discrimination in hiring: many people think that it is risky to hire a person with a psychiatric disorder because they will be unreliable or violent, whereas in reality there is no proven statistical correlation between psychiatric diagnosis and violent acts. Moreover, when people are not well, they tend to isolate themselves and go away. The willingness of some patients to work part-time in order to reconcile heavy treatment and employment can also be a problem when hiring.
Another example is education: a child with behavioral problems may end up being home-schooled because of the lack of support adapted to their needs in the regular school system. Moreover, 67% of the people questioned by the Unafam 2021 barometer were unable to complete their studies or training.

→ **Inadequate and/or inaccessible housing** [2] : Housing in itself is a complex topic, but when suffering from a psychiatric disorder, the subject is even more delicate for several reasons:

- Living independently is not necessarily taken for granted when you have a psychiatric disorder or disability. In fact, according to the barometer carried out by Unafam every year, 89% of patients do not have access to housing adapted to their real needs. Obviously, these needs vary greatly depending on the type of psychiatric disorder. For example, a person suffering from depression may have difficulty maintaining their home or managing their alcohol consumption. Some illnesses make it almost impossible to live independently (such as when suffering from Diogenes syndrome, which means accumulating rubbish and being unable to throw it away). Suffering from a psychiatric disorder also means that it is sometimes difficult to appropriate a place, to symbolize it and make it pleasant to live in, and thus in some cases to become homeless (according to Unafam, one third of homeless people suffer from psychiatric disorders).
- There are forms of housing that allow for autonomy while providing medical, psychological and social support: the "Maden" in Finistère is an example (Maison d'accueil, d'accompagnement et d'entraide mutuelle). This is a permanent form of housing that combines individual accommodation with time for collective exchanges and support. However, there are only three in Finistère, so they are of course full. Other shelters and mixed structures exist but in insufficient number. Adapted housing is often out of town, especially far from services and care, which is also a problem.
- The problem is often also economic: people with psychiatric disorders have less access to employment and therefore less money. Adapted or less expensive housing is often isolated and not easily accessible by public transport, which makes it more difficult to find a job.

1 Baromètre Unafam 2021 disponible sur unafam.org

2 Cette partie a été rédigée à partir de l'émission de RADIO EVASION avec le GEM de Quimper et l'Unafam 29 du 24/01/2022 disponible sur radioevasion.net

# DOSSIER: PSYCHIATRIC DISORDERS

→ **Degrading practices in some psychiatric hospitals** [1] : Full-time hospitalization can be accompanied by more or less serious violations of patients' dignity and rights: compulsory pyjamas, rooms without showers and television, no external visits,... The situation has worsened with the health measures linked to the spread of COVID 19, with, for example, patients being locked up day and night to protect them from the spread of the virus, or the difficulty of accessing the vaccine against COVID 19 and the "pass sanitaire".
In addition, health care staff sometimes adopt generalized methods for all patients in these healthcare facilities, whereas care is very personal, especially in psychiatry: case-by-case measures are therefore more appropriate. The lack of financial and human resources partly explains these practices: France lost more than 7 psychiatric beds per 10,000 inhabitants between 2006 and 2017, according to Eurostat figures.

→ **Poor care for physical problems**: There is a difference in the way people with and without psychiatric disorders are treated in the medical community. Let's take an example:
A person comes to the emergency room of a hospital with severe stomach pains. At the reception desk, the nurse recognizes, from the shake of their arms and the stiffness of their walk, certain side effects of neuroleptic medication. He asks them if they are being treated for a psychiatric disorder. When they answer in the affirmative, he refuses to treat them for their pain, even though it is a physical pain, and refers them to the psychiatric emergency room. Indeed, since they were a patient suffering from a psychiatric disorder, the nurse wrongly attributed their stomach ache to their psychiatric illness, assuming that it was a delusion due to their disorder and that they did not really have a stomach ache. As a result, the patient will wait longer to be examined and treated, which may put them at risk
People with psychiatric disorders also face major difficulties in accessing a general practitioner despite having a priority card.

→ **Acts of violence**: All discrimination is violence against the person with psychiatric disorders. They cannot feel at home in a society that looks at them negatively and points fingers at them, which leads to physical suffering. Moreover, several studies converge to underline the revictimization of people suffering from severe psychiatric disorders: they are **7 to 17 times more frequently victims of violence than the general population.** [2] This involves acts of various types: from harassment to rape, abuse and physical violence, in all places including hospitals. Their particular vulnerability means that these people rarely report the abuse they suffer, particularly in institutions or in the family environment. In contrast, **only 3% to 5% of violent acts are committed by people with psychiatric disorders.** [2]

→ ...

1 Cette partie a été rédigée à partir de l'article de Le Figaro "Soigner avec dignité : alerte sur les pratiques dégradantes dans les hôpitaux psychiatriques", de Marie-Liévine Michalik, datant du 19/06/2020, disponible sur lefigaro.fr

2 Haute Autorité de Santé, "Audition publique – Recommandations de la commission d'audition
Dangerosité psychiatrique : étude et évaluation des facteurs de risque de violence hétéro-agressive chez les personnes ayant des troubles schizophréniques ou des troubles de l'humeur", Mars 2011

# DOSSIER: PSYCHIATRIC DISORDERS

## AS A RELATIVE, HOW TO BEHAVE?

Psychiatric disorders are very confusing for the person living with them and for those around them. This can lead to misunderstanding on both sides, anxiety and even fear or anger, which are never good in this case. **The aim is to contribute to a peaceful climate and relationships for everyone.** Here are some good behaviors to adopt:

### AVOID

- Brutally contradicting the person
- Denigrating their views
- Imposing your interpretation or trying to prove them wrong
- Making ironic comments or criticisms
- Minimizing anxieties, phobias
- Showing annoyance
- Cutting off speech
- Giving too much information at once
- Blaming
- Raising your voice
- Threatening, confronting

### TRY TO

- Create a reassuring atmosphere
- Repeat calmly
- Understand and acknowledge that their perception is different from yours
- Take into consideration the person's suffering
- Establish a relationship of trust
- Recognise that there is no ill will
- Be patient
- Accept their slowness
- Understand the aggressiveness associated with irritation
- Understand that it is a defense against anxiety
- To value every positive initiative

**Remember that these are disorders that cause great suffering: the person needs care and attention!**

## IS THERE SUCH A THING AS RECOVERY IN MENTAL HEALTH?

**Recovery from a mental health problem is similar to recovery from a physical problem.** Recovery in the context of psychiatric disorder refers to the person's experiences as they accept and overcome the challenge of their disorder. It is about finding a balance in their daily lives that takes into account their vulnerabilities, while building on their strengths, resources and capacities. There is no single way to define recovery in mental health, although it is often defined as: **"[...] a way of living a satisfying life that is hopeful and productive despite the limitations resulting from the disorder. Recovery goes hand in hand with the discovery of new meaning and purpose in life, as the devastating effects of psychiatric disorder are overcome."**(1)

**Recovery is therefore not the same as cure.** Depending on their needs, people who have recovered from a psychiatric disorder can continue to receive care, such as psychotherapy, medication,... The disorder is still present, but it does not prevent the person from making plans. Living with symptoms, sometimes experiencing relapses, is part of building the recovery process.

Many factors can contribute to recovery:

1 Anthony W.A, "Recovery from mental illness: the guiding vision of the mental health service system in the 1990s.", Psychosocial Rehabilitation Journal, 1993

→ **Hope for an open future**: The onset of a psychiatric disorder makes the future difficult to envisage for the person concerned. Some of their plans are called into question. Hope for an open future, in which the person retains the possibility of making choices, is essential to enable a positive evolution of their psychological state.
→ **Acceptance of the disorder**: Accepting the disorder is often seen as the first step in rebuilding the person's identity after diagnosis. This consists, first of all, of considering the psychiatric disorder as one experience among others. And then to realize that, although it cannot be made to disappear, it can be dealt with and the symptoms can be controlled.
→ **Recognition as a person and not a disorder**: The person who receives a psychiatric diagnosis is not just a symptom or a disorder. Before being a patient, they are a person. Their mental health problem is one element among others in their identity: the person is an employee, a trustworthy friend, a mountain hiker, a musician or a religious person, and they are also affected by a psychiatric disorder.
→ **The power to act autonomously**: Each person must be able to act autonomously and for themselves. The person who recovers gradually increases the level of choice, decision, influence and control they have over the events of their life and environment.
→ **Control over symptoms**: By gaining the power to act autonomously, the person also increases their control over symptoms related to the disorder. For example, many people in recovery report that they develop personal strategies to be less disturbed by anxiety, OCD routines or auditory hallucinations. Some people who hear voices, for example, have developed the habit of setting a specific time during the day when they make themselves available to respond to them. This prevents them from being interrupted in their activities the rest of the time.
→ **Involvement in meaningful actions**: Gaining empowerment also allows the person to engage in projects that are meaningful to them. For one person, this might mean joining an association as a volunteer, for another, participating in the marking of hiking trails in their municipality. However, getting involved in an action that is valued by others allows a person to regain social status. It also provides a sense of belonging to a community.
→ **Mutual aid**: People who talk about their recovery frequently mention one or more "significant" encounters in their journey. This may be a peer who is also living with a psychiatric disorder, a friendly encounter, a family member who proves to be a strong support, a mental health professional. "That is to say, at the moment when they were about to give in to the disorder, someone believed in them, hoped "for them"", explains Elie Peneau, in his medical thesis defended in 2014.
→ **Doors to knock on**: In order to recover, the person can rely on various places and structures open to those living with a psychiatric disorder.

**Recovery from psychiatric disorders is possible regardless of diagnosis. Psychiatric disorder affects people in different ways and the recovery process varies from person to person. One of the foundations of recovery is hope. Society's attitudes and assumptions about psychiatric disorders also have a significant impact on a person's disorder and recovery.**
**More generally, talking to people who are themselves experiencing recovery, that is, peers or peer helpers, is a great help. They can convey hope for a satisfying life after or with the disorder and can help to break the isolation by sharing similar experiences.**

# DOSSIER: PSYCHIATRIC DISORDERS

## Focus on the "Au Petit Grain" mutual support group (GEM: Groupe d'Entraide Mutuelle) in Brest

The GEM "Au Petit Grain" is **an association that allows people suffering from psychiatric disorders and/or who are isolated to meet** in a house that serves as a meeting place. This **non-medical** association gives its members the opportunity to **regain their place in society, to have a voice and to recognize themselves in others and in their journey.**

**Many varied activities are organized** each week such as relaxation, pilates, adapted sports, writing workshops, comic book workshops, cinema, theater or concert outings, short trips outside, exhibitions, gardening, board games,... These activities are provided by external facilitators, volunteers or members of the GEM. The GEM has even launched its own music group: the "GEM's Band" composed of several members. Collective meals are also organized to strengthen the link between GEM members. Social aid and the GEM's treasury allow members on low incomes to benefit from reduced rates for paying activities, and thus to participate in activities to which they would not otherwise have access.

In addition to the activities provided by the GEM, **the house plays a central role in the functioning of the GEM.** It is **a friendly, caring and non-judgmental space** where members can meet to discuss and exchange ideas over a coffee or a meal. There is a real family spirit that allows members to find support in difficult times.

**The members are involved in the proper functioning of the house and the various projects set up at the GEM** by proposing their ideas, which are then discussed at meetings. **They are also involved in the associative life of the GEM** by taking part in the Board of Directors, the General Meeting, the meetings with the partners of the territory, by being part of the office,... Facilitators are also present to provide support, whether it be to listen, guide, supervise, animate or to help with the management of the association.

**The GEM thus offers a secure framework to its members, allowing them to open up to the outside world, create social links, try new things, and acquire a large number of associative skills and know-how that are useful in everyday life.** In addition, many of the members are now in contact with each other outside the GEM or in the context of external voluntary work. The system of voluntary work, in contrast to the world of work, is a model that also allows members to take the time to learn and gain skills without any pressure. Finally, the GEM plays an important role in **destigmatizing psychiatric disorders,** especially among outside facilitators and GEM partners. Similarly, trainees and civic service volunteers often decide to get involved in the GEM.

There are six GEMs in Finistère, four of which are in Brest, the list of GEMs in France can be consulted on psycom.org. As all GEMs are different, it is important to find the one in which you feel most comfortable. However, social links can also be created between members of different GEMs as joint activities are regularly proposed.

GEM "Au Petit Grain"

192, rue commandant Drogou - 29200 Brest

aupetitgrain.psb@croix-rouge.fr

@aupetitgrain: Facebook page

02 98 01 25 06

# DOSSIER: PSYCHIATRIC DISORDERS

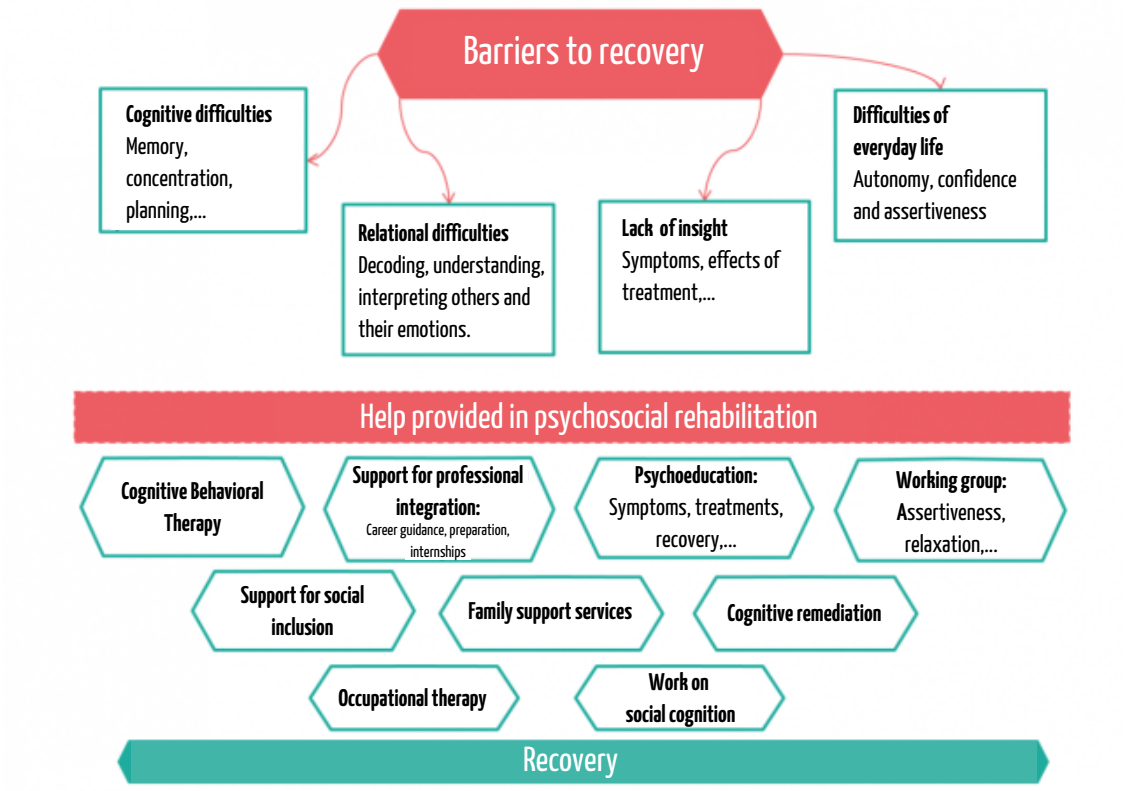
**The recovery movement has been largely driven,** first in the United States and more recently in France, **by people living with psychiatric disorders.** However, the lack of resources and available places in France is slowing down the development of psychosocial rehabilitation. Thus, 63% of relatives declared in the Unafam 2021 barometer that their loved one does not benefit from a personalized psychosocial rehabilitation care project. This treatment approach should however be introduced very early in the process, as is functional rehabilitation care for people with a physical disability, in order to minimize the consequences.

The term **psychosocial rehabilitation** [1] refers to a set of processes aimed at helping people living with psychiatric disorders to recover. It concerns different fields of the person: clinical (symptoms, treatments), functional (cognitive and relational capacities, autonomy) and social (housing, budget management, return to employment). Rehabilitation is based on the person's own goals and resources, in order to help them make life choices, taking into consideration their symptoms and any associated disabilities.

Most of the symptoms induced by psychiatric disorders can be stabilized with medication. However, certain difficulties often persist:

- **Cognitive difficulties**: memory, attention, executive functions, slowness of processing,...
- **Social cognition difficulties**: decoding, understanding, interpreting others and their emotions, being assertive in different situations,...
- **Lack of insight**: difficulty in understanding the disorder, recognizing symptoms and the effects of treatment,...
- **Loss of autonomy**

All of these difficulties are important and can interfere with the recovery process. Cognitive problems can make it difficult to return to work, as it is difficult to work if you cannot remember instructions or arrive on time, for example. The aim of psychosocial rehabilitation is to reduce the impact of these difficulties to promote recovery.
An assessment is always the basis of a rehabilitation programme, which provides a personalized approach to the person's situation.




1 Cette partie a été rédigée à partir du site internet : centre-ressource-rehabilitation.org. Le schéma en est également tiré.

# DOSSIER: PSYCHIATRIC DISORDERS

## WHICH PROFESSIONAL TO CONTACT?

**True or False?**
**"35% of people with psychiatric disorders have been hospitalized more than 5 times."**

True! This figure comes from the Unafam 2021 barometer. It shows that there are still too few mobile teams, which meet people where they live, to be as close as possible to their needs. However, the development of more mobile teams could help reduce rehospitalization and the suicide rate.

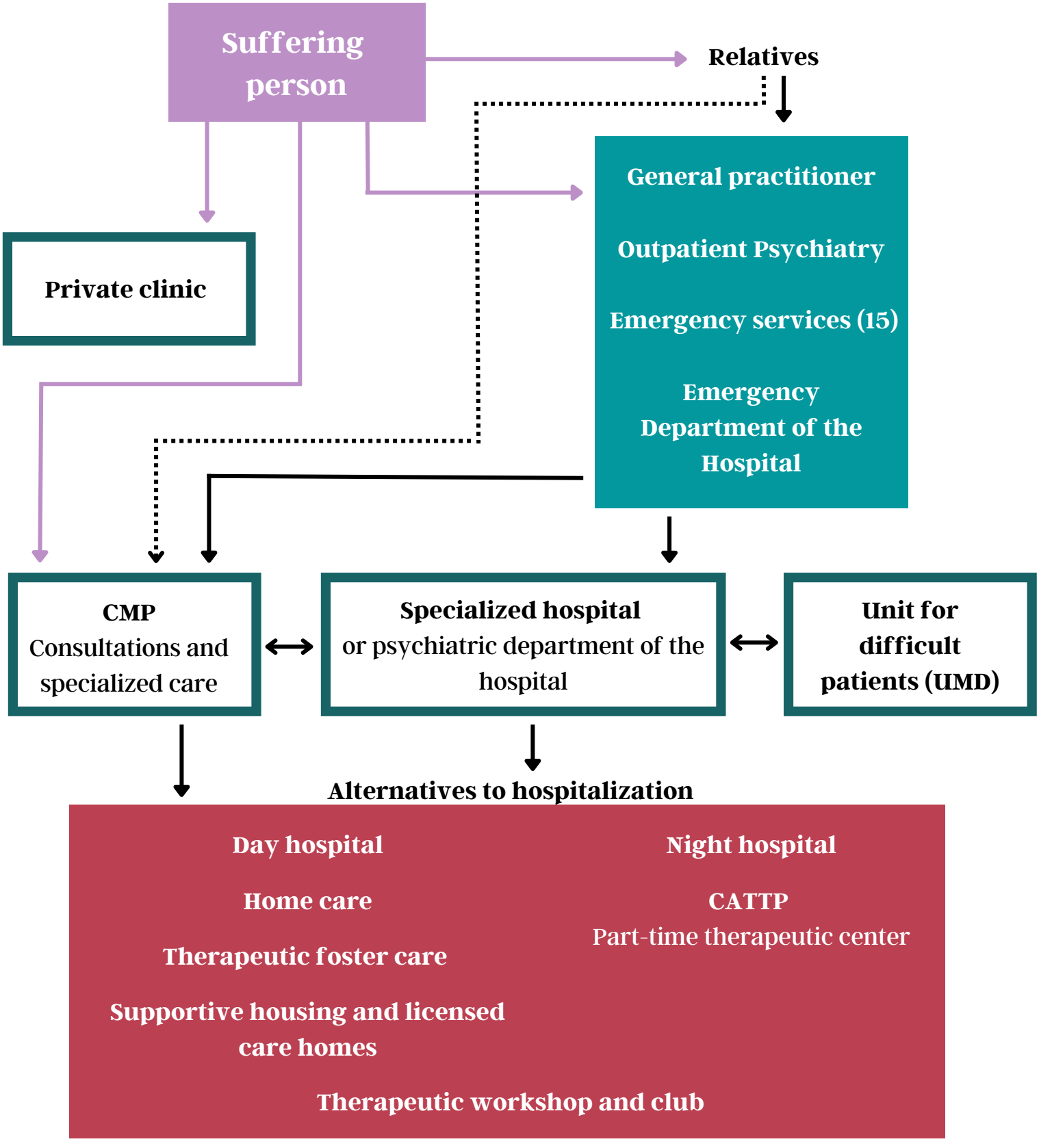
When we experience mental health problems, we can turn to qualified professionals to assist us in our care and recovery. Some work in a practice in the city, others in ambulatory services, hospitals, clinics, or other public, private or associative structures.
Often, the interventions of these psychiatric professionals are complementary. **Each one provides a different kind of support and it is their combination that promotes recovery.** Most public psychiatric services bring together a range of professionals in what is known as a multidisciplinary team.

The list below shows the different types of professionals that may be encountered:

- **Social worker:** They help individuals improve their quality of life by ensuring access to basic needs such as food, shelter and safety.
- **Art therapist:** They encourage the person's creative abilities.
- **Healthcare executive:** They care about the patients' needs and partner with other medical staff to discuss necessary changes.
- **Specialized educator:** They advise and accompany the person in their daily activities to help them become independent.
- **Occupational therapist:** In psychiatry, they help the person to acquire or recover as much autonomy as possible in their daily life.
- **Nurse:** They provide medical monitoring of the person and also give psychological support.
- **Advanced practice nurses:** Their missions are between those of the psychiatrist and the nurse.
- **Peer support specialist:** They have experienced a psychiatric disorder and have recovered, so they use their knowledge and personal experience to help their peers.
- **Neuropsychologist:** They identify deficits in cognitive functions (memory, attention,...) and highlight the person's retained abilities.
- **Speech-language pathologist:** They are specialized in oral and written language disorders.
- **Peer helper:** They are involved in mutual aid in mental health, after a personal journey that has enabled them to recover.
- **Psychoanalyst:** They provide talk therapy, during which the person being analyzed lies on a couch to talk, for example.
- **Psychiatrist:** They are a doctor and can make a diagnosis, prescribe medication, non-medical treatments, examinations, decide on hospitalization and write medical certificates.
- **Psychologist:** They are a specialist in human thoughts, emotions and behavior.
- **Psychomotor therapist:** They are a paramedical professional, specialized in problems of gesture, control of movement and body image.
- **Alternative medicine doctor:** They are a specialist in Gestalt therapy, Ericksonian hypnosis, problem-solving brief therapy according to the Palo Alto school,...
- **Psychotherapist:** They are specialized in psychotherapy, the psychotherapist may be a psychiatrist, a non-psychiatric doctor, a psychologist or a psychoanalyst, having completed their initial education if necessary.
- **Sophrologist:** They are a specialist in techniques that act on both the body and the mind, such as breathing techniques, muscle relaxation and relaxation.
- **Therapist:** Therapist is a term used to describe all caregivers, it does not correspond to any specific degree or skill.
- ...

# DOSSIER: PSYCHIATRIC DISORDERS

The organization of care in psychiatry can differ considerably from one person to another. However, below is a general schema that summarizes the recurrent support services in psychiatry for an adult person.



# DOSSIER: PSYCHIATRIC DISORDERS

## RESOURCES

This article was written in collaboration with Unafam 29 and is based on the resources provided by Psycom as well as the French Mental Health First Aid manual (unless specifically mentioned).

→ Unafam (Union nationale des familles et amis de personnes malades et/ou handicapés psychiques), an association recognized as being of public utility, has been supporting the relatives of people living with psychiatric disorders since 1963. It operates throughout France and in each department in particular.

In Finistère and Côtes d'Armor, the association has reception points in Quimper, Brest, Morlaix, Carhaix, Châteaulin and Guingamp. Listening, supporting, educating, defending the rights of the people concerned and their families and fighting against prejudice are the missions of 2,000 volunteers. With 15,000 members and 300 reception points, Unafam offers support from peers to break isolation and help people find the strength to move forward.

unafam.org
service écoute familles (listening service for families): 01 42 63 03 03
Reception points in Finistère and Côtes d'Armor:
- BREST: 06 74 94 09 21 - 29@unafam.org
- QUIMPER and CHATEAULIN: 07 88 17 72 32 - unafam29.quimper@gmail.com
- MORLAIX: 06 30 67 41 74 - unafam29.morlaix@gmail.com ("point DOC" with books and magazines on mental health)
- CARHAIX: 06 41 46 35 93 - unafam29.carhaix@gmail.com
- GUINGAMP: 06 26 13 60 41 - 22@unafam.org (or help by phone in Saint-Brieuc: 07 74 25 55 49)

→ Psycom: Psycom is a public information, communication and anti-stigmatization organization on mental health. It has been mobilizing for 25 years to address preconceived notions about psychiatric disorders. It distributes free information brochures throughout France, offers a resource site for experts and the general public, and works in a network with mental health stakeholders (from professionals to user associations, including researchers and the people concerned).

psycom.org

The Mental Health First Aid (MHFA) program was developed in 2000 in Canberra, Australia by a mental health educator in collaboration with a mental health researcher. This program aims to broaden the principle of first aid training to include psychiatric disorders. PSSM France has adapted the original program to the French culture and health system. As of mid-June 2019, more than 3 million people have been trained worldwide.

pssmfrance.fr

## RPPS / Adeli numbers

Doctors who are legally authorized to practice have an RPPS number (Répertoire Partagé des Professionnels de Santé). Other health professionals such as occupational therapists, nurses or psychologists are listed by their Adeli number (Automatisation des listes). You can find the official RPPS or Adeli directories on:

→ **annuaire.sante.fr**

→ **conseil-national.medecin.fr**: official website of doctors

→ **ordre-infirmiers.fr**: official website of nurses

## University health care services: SUMPPS Brest, Quimper/SSE St-Brieuc

| SUMPPS Brest (29238) | SUMPPS Quimper (29000) | SSE Saint-Brieuc (22000) |
|---|---|---|
| 13 rue de Lanrédec | 18 Avenue de la Plage des Gueux | 2 Avenue Antoine Mazier |
| **02 98 01 82 88** | **02 90 94 48 15** | **02 96 60 81 61** |

All information on: **univ-brest.fr** (Brest and Quimper) / **sse.univ-rennes.eu** (Saint-Brieuc)

## For disabled students: HANDIVERSITÉ UBO/Relais Handicap St-Brieuc

| Contact Brest (29238): | Contact Quimper (29000): | Contact Saint-Brieuc (22000): |
|---|---|---|
| 20 Avenue Le Gorgeu - Building C | handiversite@univ-brest.fr | Campus Mazier - Building B |
| handiversite@univ-brest.fr | IUT : **02 98 90 02 27** | relais-handicap@univ-rennes2.fr |
| **02 98 01 82 99** / **02 98 01 69 43** | Centre de Vie Étudiant : **02 90 94 48 15** | **02 96 60 43 17** |

All information on: **univ-brest.fr** (Brest and Quimper) / **univ-rennes2.fr** (Saint-Brieuc)

## Hospital psychiatric emergencies

CHRU in Brest (La Cavale Blanche): **02 98 34 74 66**

CH of Cornouaille/Quimper (Laënnec): **02 98 52 63 98**

CH in Saint-Brieuc (Yves Le Foll): **02 96 01 75 07**

All information on: **chu-brest.fr** / **ch-cornouaille.fr** / **ch-stbrieuc.fr**

## Departmental centers for the disabled (MDPH)

All information on: **mdph.fr** or **mdph29.fr** / **mdph.cotesdarmor.fr** for specific information

## Mutual support groups (GEM)

List on the website: **psycom.org**

## Addict'Aide, the addiction village

Addict'Aide is a website created by a psychiatrist and addictologist, for those who wish to get information and understand addictions to a product or a behavior. It allows users to assess themselves by type of addiction, to locate a health professional specializing in addictions near their home and to exchange information anonymously on a forum with expert patients who have experienced addiction and have come out of it.

All information on: **addictaide.fr**

## Associations

- **Argos 2001**: Association for people with bipolar disorder and their families
argos2001.net
- **Bipolarité France** (bipolar disorder)
bipolaritefrance.com
- **France Dépression**: Association for people suffering from depression or bipolar disorder
francedepression.fr
- **Agorafolk**: The community of optimistic people with agoraphobia
agorafolk.fr
- **AFTOC**: French association of people suffering from Obsessive and Compulsive Disorders
aftoc.org
- **Revivre France**: Association for people suffering from social phobia, GAD, panic disorder, agoraphobia
revivre-france.org
- **Collectif Schizophrénies**: The "Collectif Schizophrénies" federates the main associations dedicated to schizophrenia
collectif-schizophrenies.com
- **AFDER**: French association of recovering addicts, it accompanies users and their families, regardless of their dependency
afder.org
- **Alcooliques anonymes** (alcoholics anonymous)
alcooliques-anonymes.fr
- **Al-Anon**: Help for the relatives of the alcoholic person
al-anon-alateen.fr
- **Narcotiques anonymes France** (narcotics anonymous)
narcotiquesanonymes.org
- **ANPAA Bretagne**: National association of prevention in addictology and alcoholism
anpaa-bretagne.fr
- **Soutien-etudiant.info**: Website that lists all the free psychological support available in the 30 academies in France and provides advice on how to take care of your mental health
soutien-etudiant.info

## Anonymous helplines (and chat*)

- Fil Santé Jeunes* (12-25 year olds): 08 00 23 52 36 (for young people)
- SOS Amitié*: 09 72 39 40 50 (suicidal thoughts)
- Argos 2001: 01 46 28 01 03
- Suicide écoute: 01 45 39 40 00 (suicidal thoughts)
- SOS suicide Phénix: 01 40 44 46 45 (suicidal thoughts)
- Drogues Info Service*: 01 70 23 13 13 (drugs)
- Ecoute Cannabis: 09 80 98 09 40 (cannabis)
- Ecoute Dopage: 08 00 15 20 00 (doping)
- Tabac Info Service: 39 89 (tobacco)
- Alcool Info Service*: 09 80 98 09 30 (alcohol)
- Joueurs Info Service*: 09 74 75 13 13 (gambling)
- Anorexie Boulimie, Info Ecoute: 08 10 03 70 37 (eating disorders)
- Santé Info Droits: 01 53 62 40 30 (health care rights)
- PASAJ* (12-25 year olds): 02 98 43 10 20 / 06 32 98 22 07 (for young people)

### Emergency phone numbers

- SAMU: 15 (medical help)
- Police: 17
- Pompiers: 18 (fire service)
- European emergency number: 112
- Hearing assisted european emergency number (via SMS and fax only): 114
- Emergency shelter: 115

FOCUS ON...

# EATING DISORDERS

## WHAT IS AN EATING DISORDER?

Eating Disorders are generally characterized by **abnormal eating patterns, a strong fear of weight gain and an intense preoccupation with body image.**
People with eating disorders can be underweight, overweight or in the normal weight range.
There are three types of eating disorders:

**→ Anorexia nervosa**
Anorexia nervosa refers to strict and voluntary dietary restriction linked to a particular mental state. It is also associated with an intense fear of gaining weight as well as a distorted body image.

**→ Bulimia**
Bulimia is characterized by recurrent and frequent episodes of disproportionate food intake, followed by behavior to compensate for the excess: purging, fasting, excessive exercise, dieting,...

**→ Binge eating disorder**
This disorder is characterized by binge eating, but without recourse to weight loss strategies to compensate (vomiting, laxatives, excessive exercise,...).

Other unspecified eating disorders exist, which include problems that do not precisely meet the criteria for an eating disorder, but are also to be taken seriously. Orthorexia nervosa, the obsession with eating healthily, or bigorexia, the impression of being too thin or never muscular enough, are some of the examples.

## WHAT FACTORS CAN LEAD TO EATING DISORDERS?

- **Life experiences:** conflicts at home, violence, history of restrictive diets in the family in the past, criticism from others about diet, weight or body shape, need to stay thin because of one's profession or hobbies (weight categories in top-level sports, modeling,...),...
- **Personal criteria:** restrictive diet, low self-esteem, perfectionism, anxiety,...
- **Family members with psychiatric disorders**
- **Society and culture:** social and cultural representations of the body, various media injunctions (ideals of thinness), promotion of risk behavior,...
- ...

Eating disorders are a way of defending oneself against unhappiness, using the body instead of words. Eating disorders, like addictions or violence, are a way of managing emotions and reassuring oneself by focusing on one thing. This response, although dangerous for the person, gives them a sense of control and relief when they are anxious.

# FOCUS ON... EATING DISORDERS

## WHAT ARE THE WARNING SIGNS TO LOOK OUT FOR?

The following questionnaire helps you to assess whether you or one of your loved ones is at risk of developing an eating disorder. Do you recognize yourself in the following statements? Do you recognize the behaviors and the thoughts of one of your loved ones?

| | | |
|---|---|---|
| **I think that people who are thinner than me are happier and have a better life** | **Yes** | **No** |
| **I am becoming more and more preoccupied with my physical appearance and with my weight** | **Yes** | **No** |
| **I often compare myself to others and their bodies** | **Yes** | **No** |
| **I often weigh myself** | **Yes** | **No** |
| **I am extremely afraid of getting fat** | **Yes** | **No** |
| **I have difficulty maintaining an appropriate weight for my age, sex and height** | **Yes** | **No** |
| **I have seen my weight change drastically in last few months** | **Yes** | **No** |
| **I keep track of the amount of calories and fat in the food that I eat** | **Yes** | **No** |
| **There are certain types of food that I do not eat anymore in order to lose weight** | **Yes** | **No** |
| **It happens that I eat very large quantities of food in a very short period of time** | **Yes** | **No** |
| **I feel guilty after eating** | **Yes** | **No** |
| **It happens that I eat in secrecy or lie when asked about what I have eaten.** | **Yes** | **No** |
| **I am very afraid that I am not able to control my weight or that I will lose control when I eat** | **Yes** | **No** |
| **I exercise excessively and if I would not be able to do it one day, I would be very frustrated** | **Yes** | **No** |
| **I exercise even if I am hurt or sick** | **Yes** | **No** |
| **I don't have my period anymore, or my period is very irregular** | **Yes** | **No** |
| **I have sudden mood swings. I especially feel emotional, irritable, depressive or anxious** | **Yes** | **No** |
| **I don't want to eat with other people** | **Yes** | **No** |
| **I isolate myself more and more and I spend less and less time with my friends and family** | **Yes** | **No** |
| **People often tell me that I should stop restricting my food intake to lose weight** | **Yes** | **No** |
| **I am often cold, tired, or feel dizzy** | **Yes** | **No** |
| **I have noticed that I am losing my hair** | **Yes** | **No** |

If you circled more "Yes" than "No", it may mean that you or one your loved ones has concerns about the body image and eating. In this case, it may be a good idea to consult specialized resources in eating disorders and talk about it to someone you trust or to a doctor.

# FOCUS ON... EATING DISORDERS

## HOW TO SUPPORT A LOVED ONE SUFFERING FROM EATING DISORDERS?

Relatives are not a substitute for a qualified health professional, but they can provide essential support to the person with an eating disorder. Also keep in mind that everyone reacts differently to the disorder, so you need to be flexible in how you support your loved one.

### What not to do:

- **Giving simplistic advice:** "Just eat less, eat more, change your mindset,...". Eating disorders are complex disorders that cannot be solved by simple, quick and obvious solutions, otherwise these techniques would be applied by everyone. Healing from an eating disorder is not just a matter of willpower but requires individualized care and support.
- **Making accusatory and guilt-inducing remarks:** "You're too skinny, you're hurting me,... "It is important to remember that eating disorders are disorders and not a deliberate choice, so it is ineffective and even counterproductive to lecture people with eating disorders. Also, use "I" rather than "You": "I worry about you" rather than the more accusatory "You worry me".
- **Focusing on food or on the person's body shape:** It is essential not to feed your loved one's obsessions, and not to let these obsessions dominate your relationship.
- **Breaking off contact with your loved one:** People with eating disorders suffer enough social isolation as it is, it is important to stay by their side.
- **...**

### What to do:

- **Identify the warning signs in your loved one and take the first step to talk about it.** It is unreasonable to think that the situation will get better on its own, which is why it is important to take the initiative to learn more about eating disorders and discuss it with the person.
- **Reassure your loved one** that they deserve to be helped, to be healthy, to be happy and that recovery is possible.
- **Help your loved one to seek help**, to consult a professional and, if necessary, to undergo treatment.
- **Support your loved one in their daily activities** and focus on their strengths, qualities, successes, achievements and interests that are not related to food or physical appearance.
- **Listen to the person's concerns and feelings,** whether they are related to the eating disorder or not. The key is to listen, rather than advise or comment.
- **See your loved one as a person first, rather than as someone with an eating disorder.**
- **Accept that you cannot play all the roles** and give your loved one enough space.
- **...**

## CAN WE RECOVER FROM EATING DISORDERS?

Recovery from an eating disorder is entirely possible, but the most important thing is to do prevention beforehand and to be able to recognize the warning signs of the disorder so that it can be detected as early as possible and dealt with before it becomes chronic. **The earlier the eating disorder is diagnosed, the faster and "easier" the recovery will be.** It is also important to keep in mind that **you can't get over an eating disorder on your own, you need to be accompanied by professionals.** It is advisable to **talk to your general practitioner first**, who can then refer you to specialized services.

Recovery is based on limiting the harmful effects of the eating disorder, but also on letting people talk about the underlying problem that led to the development of the disorder. The person is considered to be recovered when they are no longer destructive and isolated and are finally able to develop. The journey of recovery from an eating disorder can therefore be long, but **there is no fatality, it is always possible to recover and get better.**

# FOCUS ON... EATING DISORDERS

## RESOURCES

- **Psycom**: organization dedicated to mental health, and in particular to eating disorders
  - Information
  - Resources

**psycom.org**

- **Anorexie et boulimie Québec (Aneb)**: organization for people with eating disorders and their loved ones
  - Information
  - Free and anonymous help forum
  - Free and anonymous support groups on Zoom in English and French, specifically for people suffering from an eating disorder or for the loved ones

**anebquebec.com**

- **L'Union Solidarité Anorexie Boulimie (USAB)**: association which brings together associations of people suffering from eating disorders and their loved ones in France
  - Directory of regional associations specialized in eating disorders
  - Resources

**solidarite-anorexie.fr**

- **Solidarité Anorexie Boulimie Finistère (SAB 29) and Côtes d'Armor (SAB 22)**: associations for people who have been or still are dealing with an eating disorder, directly or as a loved one
  - Information
  - Meetings between those concerned
  - Resources

SAB 29: **anorexie-finistere.fr** / SAB 22: **@SAB22Cotesdarmor** (Facebook page)

- **Fédération Française Anorexie-Boulimie (FFAB)**: association of professionals working in care, prevention, training and research in the field of eating disorders
  - Information
  - Directory of specialized care services
  - Resources

**ffab.fr**

- **Autrement : pour un autre regard sur son poids**: information association on eating disorders, for patients, loved ones and professionals
  - Information
  - Questionnaire to assess whether you are at risk
  - Resources

**anorexie-et-boulimie.fr**

- **Anorexie Boulimie, Info Ecoute**: specialists in eating disorders answer your questions four days a week, from 4 pm to 6 pm
  - Monday: psychologists
  - Tuesday: associations specialized in eating disorders
  - Thursday: doctors
  - Friday: all specialists, alternating

**0 810 037 037** (0.06 euros per minute + call charge)

- **Hospital services: CHRU in Brest / CH of Cornouaille (Quimper) / CH in Saint-Brieuc**

All information on: **chu-brest.fr** / **ch-cornouaille.fr** / **ch-stbrieuc.fr**

- **University health care services: SUMPPS Brest and Quimper / SSE Saint-Brieuc**

All information on: **univ-brest.fr** (Brest and Quimper) / **sse.univ-rennes.eu** (Saint-Brieuc)

# SITUATION 1: CORRECTION

## PART ONE

The correct answer is C

It is important here to go back to the definition of the term **"street harassment"**. Street harassment corresponds to **sexual harassment taking place in public and semi-public spaces** such as the street, public transport, bars, gyms, restaurants, concerts,... Street harassment is **insistent, unwanted and one-sided**, and is therefore totally different from flirting between consenting people. Unwanted verbal, non-verbal or physical behaviors of a sexual nature such as: whistling, comments, demands, slurs, leering, lip-smacking, persistent requests, sexual names or jokes, flashing, groping, exhibitionism, sexual assault, following..., are street harassment. In this situation, the man is following this woman, whispering comments in her ear, so this is harassment, that's why answer A is wrong.

Answer B is not right either, because you have to remember that **the fact that the potential harasser and the potential victim know each other does not justify all situations.** As a general rule, if you have any doubt about the situation, **follow your instincts** and try to take action. Also consider watching the reaction of the person being harassed, if you think something is wrong, it most certainly is. And even if the situation was not what you thought it was, no one will judge you negatively for wanting to do something, quite the contrary. Moreover, in this answer you decide to take a separate street, which shows that the situation is bothering you and makes you feel unsafe yourself.

Answer D raises awareness of the **"witness effect"**, a psychosocial phenomenon in emergency situations that stops someone from helping a victim because of the presence of other people at the scene. **The more witnesses there are, the less one reacts**. However, when the first person decides to act, this often also breaks the witness effect in others, who will come to the rescue. It is therefore important to force yourself to intervene, even when there are people around you who could do it for you: someone has to start the dynamic of action for the others to react.

Answer C is therefore the only correct answer here. Street harassment is an experience that gradually destroys the self-confidence of the person being harassed, which can lead them to question themselves or doubt the seriousness of the situation. **When you witness harassment and do not take action, it aggravates the trauma of the person being harassed and reinforces the harasser's belief that what they are doing is acceptable.** Therefore, this dynamic must be broken by acting on a case-by-case basis, with the aim of building a culture in which harassment is seen as something intolerable.

# SITUATION 1: CORRECTION

## PART TWO

## The correct answers are A,B,C,D,E

All the answers are correct, they correspond to **the 5D's method**. Each "D" corresponds to a technique that can be used to intervene safely if you witness street harassment.

### DISTRACTING: A

Distracting is an indirect way of drawing attention away from a harassment situation. There are many ways to distract:

- Asking for directions, the time, or the nearest ATM machine
- Blocking the way
- Making noise
- Dropping something "accidentally"
- Pretending to know the person being harassed

**Simply standing next to the person being harassed without saying anything or talking loudly on the phone can also be effective.**

### DELEGATING: B

Ask for help. Explain to one or more people nearby what has happened and ask them if they can do anything. It is also possible to ask someone in authority. In public transport, you can ask the driver; in a bar, the barman or barmaid; in a gym, a member of staff. You can also threaten to tell the police, but always check that the person being harassed agrees.
**Asking someone to act is helping in a way.**

### DOCUMENTING: C

Discreetly record the harassment scene to provide evidence for the victim if they wish to make a complaint. If you are safe, recording can also be a way of intimidating the harasser.
This may seem obvious, but before you record a video, keep your distance, make sure you capture enough context to identify the location (street signs, traffic signs,...) and mention the date and time out loud.
And above all: do it to support the person being harassed. Always ask them what they want to do with the video. **Do not use it or publish it online without their permission.**

# SITUATION 1: CORRECTION

## PART TWO

The correct answers are **A,B,C,D,E**

### DIALOGATING: D

As soon as the incident is over (and even if the harasser is still there), check on the person being harassed. Tell them that what happened is not acceptable and that it is absolutely not their fault. For example, ask them: "Are you okay?", "Do you want me to sit next to you?", "Is there anything I can do?", or say: "You didn't do anything wrong". Act like a friend. All these phrases are a good way to show the person the support they need.

**A little empathy can do a lot, especially to reduce the psychological damage caused by the harassment.**

### DIRECTING: E

Bring attention to the situation by calling out the harasser. Only use this D as a last resort, when it is necessary to avoid violence. Your safety and the safety of the person being harassed come first. Tell the harasser that what they are doing is not acceptable and ask them to stop immediately. Ask for help without confronting the harasser directly or putting yourself in danger. Then talk to the victim to find out if they are alright.

**Avoid getting into an argument with the harasser as this can lead to more violence.**

**It is also possible to use these techniques if you are a victim of street harassment yourself.** By distracting ("You have your hand on my thigh, can you take it off?"), delegating ("Sir, I've been telling this person to stop for ten minutes, maybe with you they will listen better") or documenting.

# SITUATION 2: CORRECTION

## PART ONE

The correct answers are **C, D**

The problem with answers A and B is that they never question the role of alcohol in explaining the friend's behavior. In this situation, there are several clues that suggest that alcohol is not the problem.

First of all, **there is an inconsistency between the amount of alcohol consumed and the person's condition.** In this case, your friend seems to be drunk after only two drinks, whereas you are not at all in the same condition.
Secondly, **the signs of "being drunk" happened very quickly** (barely fifteen minutes, the time it took you to go to the toilet), much too quickly to be produced by alcohol alone.
Finally, the last sentence "It's strange, she's only had two drinks... " seems to indicate that your friend is **not behaving as usual,** or at least is not behaving this way usually after two drinks.

→ These 3 clues point to chemical submission, which can be induced by GHB for example.

Thus, even though:

- **The symptoms caused by GHB are close to being drunk**: euphoria, disinhibition, loss of balance, hot flashes, sleepiness, nausea, vomiting, dizziness, memory loss,...
- Your friend did not put her drink down unsupervised or accept a drink from a stranger
- Your friend does not appear to have been assaulted by a stranger (the aggressor is probably waiting for the victim's condition to deteriorate before taking action)
- Your friend did not smell anything special when she drank her drink **(GHB is odorless, colorless and tasteless, or very slightly salty, so it cannot be detected)**

the three clues mentioned above should still alert you to potential ghb intoxication!
Whatever happens, if in doubt, you should be concerned and take care of the person, as in answers C and D!

# SITUATION 2 : CORRECTION

## PART TWO

## The correct answer is B

Answer A is wrong for two reasons. Indeed, in case of suspected intoxication:

- The person should **not be forced to drink or to vomit**
- **The person must be kept under supervision** because chemical submission is just the first step: the person who drugged them will surely try to attack them afterwards. Also, given their vulnerable state, anyone could attack them and they would not be able to defend themselves.

Answers C and D are wrong for two reasons:

- You should **not try to transport the person,** on the contrary, **put them in the recovery position** if they lose consciousness and monitor their breathing
- You should **not let the person go home**, even if you accompany them, because their condition may worsen (coma, convulsions,...) depending on the dose administered, their weight, their height,...

Answer B is the right behavior to have when you think someone has been drugged:

- **Call the emergency services**: 15 (SAMU: medical help), 18 (POMPIERS: fire service), 17 or 114 by SMS (POLICE), 112 (EUROPEAN EMERGENCY NUMBER): **don't wait until the most serious symptoms of intoxication appear**
- **Keep the person under supervision** while calling the emergency services, reassure them and put them in the recovery position if necessary
- You can also **warn the staff members** and the person who manages the place to help you, and to ask them to **keep as much evidence as possible**: glasses, bottles, photos of the party, video surveillance,...
- Don't hesitate to keep as much evidence as possible: glasses, clothes, photos/videos of the party, testimonies,...

## IN THE EMERGENCY ROOM

- Request to be taken to a specialized hospital and to do a **GHB drug test**

Indeed, **GHB is detectable less than 6 hours in the blood and less than 12 hours in the urine**, which makes testing complicated because it must be done very quickly. After this time, it is possible to do **a hair test**. However, before doing these tests and so that the results are not false, the person who has been drugged must protect their hair **by banning bleaching, dyeing, straightening, masks, treatments, hair cutting,...**

- Also ask for an emergency appointment with the drugged person's general practitioner
- The person can also be looked after in order to search for signs of a potential sexual assault (physical signs, DNA sampling,...). Emergency contraception such as the morning-after pill and a Post-exposure prophylaxis (PEP) to prevent HIV after a possible exposure may also be provided.

CORRECTION

# TRUE / FALSE

**FALSE!** The word handicap comes from the English term "Hand in cap". This expression comes from a trading game of possessions that was practiced in Great Britain in the 16th century. In order to restore equality of value between what was given and what was received, the person who received an object of greater value had to put a sum of money in a cap to restore equity. The "hand in cap" reflected the negative, unfavorable situation of the person who drew the item of lesser value. In the 18th century, the term was used in sport, particularly in horse racing. It was used to describe the additional difficulties given to the opponents of a disadvantaged competitor, in order to give everyone an equal chance.

1

**FALSE!** About 80% of disabilities are invisible. Stereotypical representations of disability often only include the image of a person in a wheelchair, when in fact only 4% of people with disabilities use a wheelchair.

2

**FALSE!** Only 15% of disabled people are disabled from birth. 85% of people with disabilities are disabled due to diseases that occur after birth, accidents during their life or due to aging.

3

**TRUE!** If about 80% of disabilities are invisible, it is mainly because some are only visible in certain situations (hemophilia, color blindness, epilepsy,...), as opposed to a person who has to use a wheelchair on a daily basis for example.

4

**TRUE!** In France, two laws have been fundamental for the recognition of disability. The 1975 law was the first to provide a state framework for the career guidance and training of disabled people. The 2005 law integrates the social and environmental dimension of disability, beyond a strictly medical approach, and recognises five major categories of disability: motor, sensory, mental, cognitive and psychiatric.

5

**TRUE!** The mission of the MDPH (Maison Départementale des Personnes Handicapées) is to facilitate the administrative and professional procedures of users, their families or any other person.

6

CORRECTION

# TRUE / FALSE

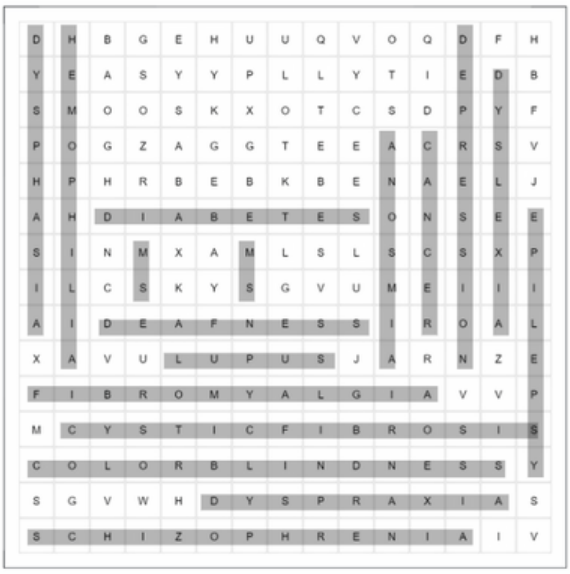
**7** **FALSE!** Employers must respect an employment rate of 6% of disabled people out of their total salaried workforce. Companies that do not fulfill this obligation, or only partially, must pay a financial compensation.

**8** **FALSE!** The "Reconnaissance de Qualité de Travailleur Handicapé" (RQTH) is an administrative status that requires a voluntary request to the "Maison Départementale des Personnes Handicapées" (MDPH). In particular, it allows disabled people to benefit from specific assistance.

**9** **TRUE!** Dyslexia is a specific disorder of written language acquisition, dysphasia is a specific disorder of oral language development and dyspraxia is a specific disorder of motor development and/or visual-spatial functions.

**10** **TRUE!**

**11** **FALSE!** Systemic lupus erythematosus is a chronic autoimmune disease. It is characterized by variable symptoms in various organs (skin, joints,...), ranging from unexplained spikes of fever, pain and swollen joints to vision problems for example. The term lupus refers to a characteristic symptom of the condition: a mask-like rash on the face called wolf (from the latin lupus).




**12** **TRUE!** Most often, these pains are associated with other signs such as intense fatigue or sleep disorders for example.

CORRECTION

# IS IT YES, IS IT NO?

## SITUATION 1: ANSWER C

Consent is **a willing agreement that a person gives when they have both the freedom and capacity to make that choice**. Someone doesn't have the freedom and capacity to agree to sexual activity by choice if: they are drunk or on drugs, they are being pressured, bullied, tricked, manipulated (by a person in authority for example: a teacher, an employer, a coach,...), if the other person is using physical force against them,... In this situation, even if the attraction between you seems to be mutual, this is no substitute for a consensual YES! Take a chance with this girl when she is no longer drunk, when she has the freedom and capacity to consent (or not).

## SITUATION 2: ANSWER A

Remember that **non-consensual sex is sexual assault or rape**. It is therefore crucial to know when to stop and to be sure that the sex is consensual from start to finish. If sexual activity has to stop because it is no longer consensual, you may feel sad or frustrated, but you should remember that it would not be good for either partner to continue the sexual activity under these conditions. Finally, keep in mind that **silence and the absence of a NO are not the same as consent.**

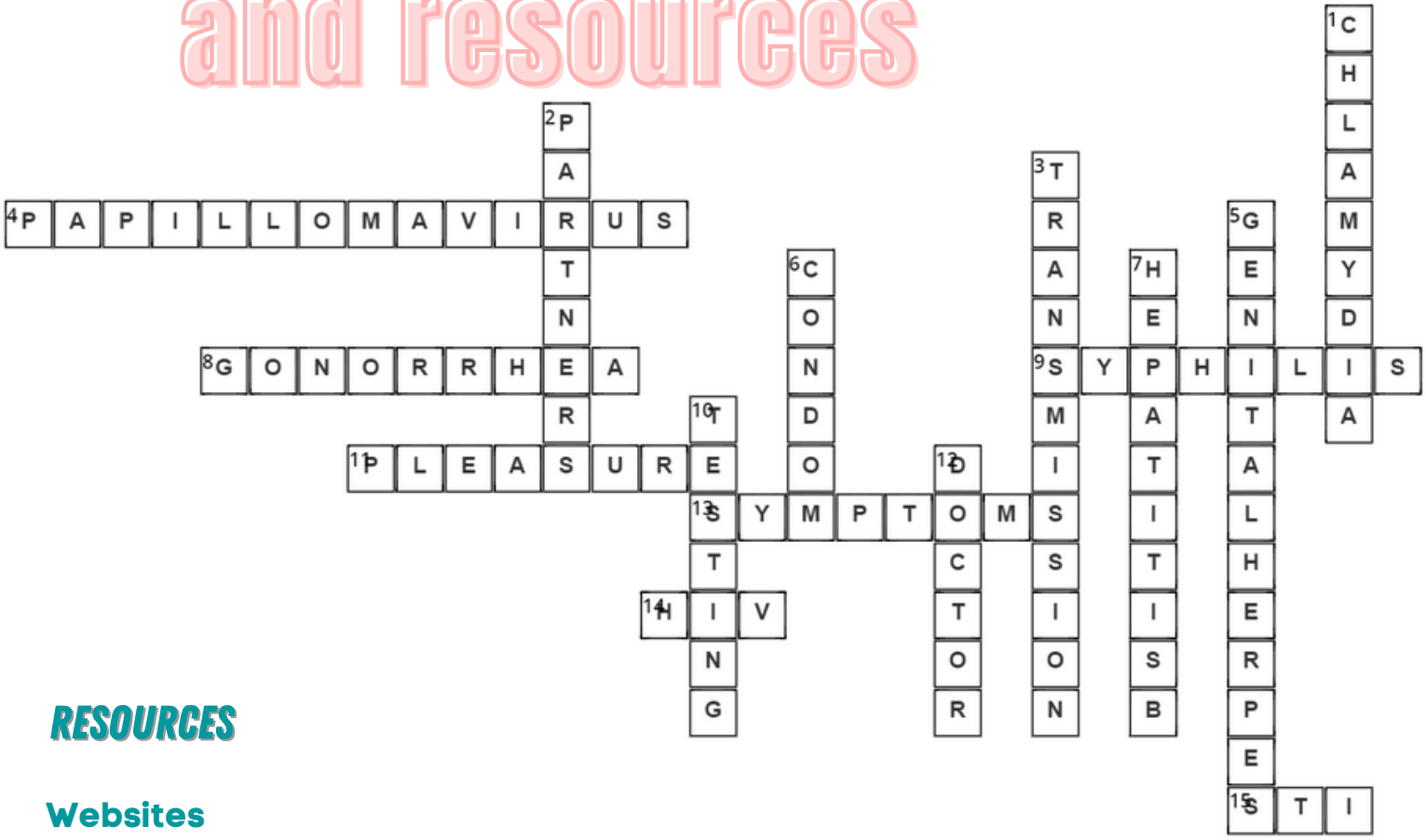
## SITUATION 3: ANSWER D

It is **not because someone has consented or will consent to do something, that at the moment that person will also consent to do the same thing.** In this situation, it can be normal to feel disturbed, but it should not be forgotten that if the person has not talked about it before, it is probably because it is a sensitive subject for them: you should not force the discussion, but rather wait until the person feels ready to discuss it. Also, just because you think being in a relationship means having sex, it doesn't mean that everyone shares this point of view!

## SITUATION 4: ANSWERS A, C AND D

Of course, **neither a person's behavior (in this case, suggestive dancing) nor outfit is an invitation to an unconsented act.** Since you can never be sure what the other person wants, it is important to ask for their consent before any approach, even if they seem interested. Also, just because you have consented to something (in this case dancing with this girl) does not mean that you have to consent to it again a few moments later or when the nature of the action changes (in this case the dancing has become very suggestive). Remember that **the purpose of consent is for the people involved to be on the same wavelength!**

# CORRECTION
# and resources




## RESOURCES

### Websites

- onsexprime.fr (general information on sex life)
- sida-info-service.org (information on AIDS)
- preventionsida.org (information on AIDS)
- hepatites-info-service.org (information on hepatitis)

### Anonymous and free helplines and chat

- Sida Info Service (AIDS): **0 800 840 800**
- Hépatites Info Service (hepatitis): **0 800 845 800**

### Free and anonymous STI testing

**With the hospital / CHRU in Brest** (chu-brest.fr):

- Permanent STI testing by appointment: CeGIDD Brest

Hôpital La Cavale Blanche
Boulevard Tanguy Prigent - 29200 Brest
Secretariat: 0 800 081 329 (toll-free number) / 02 98 34 72 07

- Mobile STI testing: Brest, Lesneven, Landerneau, Carhaix, Morlaix, Châteaulin

**With the hospital / CH in Saint-Brieuc** (ch-stbrieuc.fr):

- Permanent STI testing by appointment: CeGIDD Saint-Brieuc

Hôpital Yves Le Foll
10 rue Marcel Proust - 22027 Saint-Brieuc
Secretariat: 02 96 01 72 99

**With the hospital / CH of Cornouaille** (ch-cornouaille.fr):

- Permanent STI testing by appointment: CeGIDD Quimper

Hôpital Laënnec
14 bis avenue Yves Thépot - 29107 Quimper
Secretariat: 02 98 52 62 90

**With the association "AIDES"** (aides.org):

- AIDES Brest:

16 rue Alexandre Ribot - 29200 Brest
02-98-80-41-27 / 06-80-66-78-52
brest@aides.org

- AIDES Quimper:

25 route de Brest - 29000 Quimper
02-98-95-67-96 / 06-16-01-40-29
quimper@aides.org

### General information

- **Sida Info Service** (AIDS):
sida-info-service.org

Guidance directory (associations, screening centers, hospital services,...)

- **SUMPPS Brest***:
13 rue de Lanrédec
29238 Brest
02 98 01 82 88
univ-brest.fr

- **SUMPPS Quimper***:
18 Avenue de la Plage des Gueux
29000 Quimper
02 90 94 48 15
univ-brest.fr

- **SSE Saint-Brieuc***:
2 Avenue Antoine Mazier
22000 Saint-Brieuc
02 96 60 81 61
sse.univ-rennes.eu

*university health care service