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ORIGINAL ARTICLE

Sexual abuse and intellectual disability: Awareness for a better intervention[☆]



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Accepted 12 March 2014

Available online 30 September 2014

KEYWORDS

Sexuality;
Handicap;
Violence;
Psychological trauma;
Diagnosis;
Treatment

Summary Many intellectual disabled persons, victims of sexual violence—more frequently than in the valid population—cannot still be taken seriously and, consequently benefit from the necessary specific care. Their cognitive and mnesic difficulties of chronological benchmarks, in space, comprehension or (verbal or non-verbal) elocution are sources for mistakes, insufficiencies and contradictions within their own answers are often the cause for doubting about their credibility, and disability as an aggravating circumstance concerning law matters may backfire on these victims. The recent neurobiological works on psychological traumas with severe consequences on mental health will be at first introduced. They involve specific psychic disorders, post-traumatic stress disorder with syndromes of revivification and avoidance and/or dissociative symptoms, and physical health—neurovegetative and hyperactivity—disorders. Secondly, we deal with situations of two young persons who were victims of sexual abuse and had developed a post-traumatic pathology with traumatic memory that was not diagnosed as such in their specialised institution and in the psychiatric hospital. Families had to find the specific treatment allowing to stop the psychic-medicine escalation and the directing toward hosting structures. Prior to their treatment is the family and social attitude toward violence to disabled persons.
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It is, unfortunately, an observation that young intellectually-impaired people who are victims of sexual abuse cannot be

taken seriously and consequently benefit from compulsory specific treatment. The commission of inquiry on “*abuse toward disabled people in institutions, social and health-care services and (on) means to prevent it*” (25 000 in France) observed “a limited interest for abuse of disabled people from many (state) institutions”: either social or the health-insurance and/or justice department concerning protection of vulnerable adults (report n°339 presented to the Senate on the 5th June 2003, page 61). “The commission of inquiry during its investigation not only observed the lack of reliable statistics concerning acts of abuse on dis-

DOI of original article: <http://dx.doi.org/10.1016/j.sexol.2014.03.002>.

[☆] La version en français de cet article, publiée dans l'édition imprimée de la revue, est également disponible en ligne : <http://dx.doi.org/10.1016/j.sexol.2014.03.002>.

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<http://dx.doi.org/10.1016/j.sexol.2014.03.001>

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abled persons but also the embryonic number of statistics themselves... In 2002, 209 cases of abuse recorded in social and healthcare institutions have been transmitted to the General Director for Social Affairs... The most frequently-recorded cases of violence are cases of sexual abuse representing 48%, i.e. 104 cases, including 30 rapes... An administrative inquiry is conducted in over half the cases—56.6%—and the public prosecutor is referred to in 84% of the cases” (page 69). “Training to the issue of abuse is also recent and embryonic concerning not only medical and paramedical professions but also managers of institutions and social and healthcare services” (page 63), developed after Law 2002–2 (renovating social and healthcare action in order to guarantee rights and individual freedom for the users). The aim of this article is to have an interest for behaviours linked to traumatic memory after sexual abuse among behaviours that can be observed in teenagers and young adults with intellectual impairment (Blanc and Juilhard, 2003).

The psychological traumas

Sexual abuse consists of a physical aggression and of a psychic breaking-in of various intensity pending on what is unconceivable and atrocious. The World Health Organization (WHO) defines violence as “the threat or the intentional use of physical strength, of power against oneself, another being or a group or community, which results in or may highly result in a trauma, death, psychological damages, ill-development or deprivation”. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines “the antisocial personality disorder” as “a pervasive reason for ignorance and invasion of the other’s rights since the mental age of 15...” (APA - American Psychiatric and Association, 1996). It is detailed that “exposure to violence when young or mistreatment during childhood may also contribute to developing the antisocial personality disorder”.

Recent neurobiological works on psychological traumas

Let’s remind it: man’s brain has mirror neurons involved in understanding someone else’s actions, in learning by imitation of complex actions and visualization of actions. Another aspect of the human brain has been recently found: a “neuro-social” one, a “relation intelligence” via “spindle neurons” that automatically echo with someone else’s neurons, some kind of internal (non-externalized) mimetic ability which structures the neuron networks according to the relation experiences. And this is complementary to the neuron structures of the neocortex, the “civilized brain” that is adjustable and able to think.

Violence, because of its intentionality is a trauma that provides mostly psychological traumas (about 40%). Psychological traumas are “normal, serious, long-lasting and frequent consequences on mental health of abnormal situations: frequent violence” (Salmona, 2008, p. 153). They involve specific psychic disorders, post-traumatic stress with syndromes of revivification and avoidance and/or physical health—neurovegetative, hyperactivity—disorders. Crocq in 1992, defines the psychic trauma or psychological trauma as

“a phenomenon of breaking in the psyche and overwhelming the defence system through violent excitement linked to an aggression event or threatening life or the (physical or psychic) integrity of an individual who is exposed as a victim, witness or actor” (Crocq, 1992, p. 59).

The response from the body when endangered is activated by the brain amygdala receiving many sensory perceptions more rapidly than the cortex; “bypassing the cortex allows the amygdala to respond to the danger even before the individual has understood what happened” (Ledoux et al., 1997, p. 1721). When warned by stress situations, the amygdala activates via the thalamus a secretion of hormones—mainly adrenaline and cortisol—acting on the heart rate, pain perception... so that the body can react: escape, fight. When the danger’s over, the system is deactivated and hormones rates are back to normal: “the brain is the key organ of the stress response because it determines what is threatening, and therefore, stressful, and also controls the behavioural and physiological responses” (McEwen, 2006, p. 368) mainly by the intervention of the hippocampus via the thalamus. Despite the complex reasoning of the cortex, if the amygdala feels that danger is still around, it orders the thalamus to go on flowing the body with hormones... which ends up with affecting the hippocampus function and causing a state of continuous excitement with damaging consequences for the body (myocardial failure, stomach ulcer...) “animal studies have suggested that early stress is associated with alterations in the hippocampus” (Bremner et al., 2003, p. 930, Nemeroff et al., 2009). “This vital risk forces the brain to implement mechanisms of exceptional neurobiological safeguard allowing to switch off the emotional response, short-circuiting the amygdala and then protecting the heart and the brain” (Salmona, 2008, p. 77). Disjunction of the emotional circuit happens thanks to—among others—a release of neurotransmitters by the brain which are endogenous morphine-like and ketamine-like hard drugs: “these results reveal that AMPA and NMDA receptors within the amygdala make dissociable contributions to the expression and extinction of conditioned fear, respectively” (Krystal et al., 1995, Zimmerman and Maren, 2010, p. 1668). For Ruth et al. (2010), p. 645: “As soon as a limit of anxiety is reached, the model of cortolimbic inhibition presents that the medial prefrontal cortex stops the treatment of emotions in limbic structures such as the amygdala which in turn leads to a control of the sympathetic response and reduces the emotional experience”, which seems to imply that there is a transitory psychological withdrawal of information linked to the trauma. Dissociation implies the separation of emotional and oppressive contents of the experience during and after the trauma.

Emotional memory of violence remains then stuck in the amygdala and untreated by the hippocampus (which treats and encodes conscious memory, learning and time-space benchmarking); it cannot become an autobiographical memory which tells about itself and whose emotive load modifies itself through the years (Van der Kolk and Van der Hart, 1991; Krystal et al., 1995). This trauma memory remains as such, unchanging with the initial emotional load (fear, distress, “even disorders in the basic visceral functions” Janet, 1923, p. 190), as an implicit memory without image or any social role (Salmona, 2008). “Like a land mine, it may explode” (Salmona, 2013, p. 78) to start at

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