

CHILDREN VICTIMS OF SEXUAL ABUSE

TRAUMATIC MEMORY: SEXUAL ABUSE AND PSYCHOTRAUMA

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The first victims of sexual violence are children, girls being three to six times more numerous than boys: one in five girls (Hillis, 2016, WHO, 2016), and one in thirteen boys (WHO, 2014) are sexually abused. In addition to being a serious violation of their rights, sexual abuse has heavy psychotraumatic consequences on the short, medium and long term. It impacts their health, education, emotional, sexual and social life, and it increases likelihood of these children's revictimization.

The lack of screening, protection and care is a big loss of opportunity for abused children, especially because they could benefit from very effective care. Recognizing such abuse and its consequences on health, detecting, protecting, treating, and rendering justice to the abused children is an absolute imperative and a public health emergency.

I. THE REALITY OF CHILD SEXUAL ABUSE

1- Alarming numbers

Victimization studies in France show that 59% of women and 67% of men who are victims of rape and attempted rape were abused as minors. It is estimated that, while every year 86,000 women and 16,000 men are victims of rape and attempted rape, children are far more likely to be victims: 124,000 girls and 30,000 boys (CVS 2012-2015 and CST INSERM survey, 2008). The results of the Impact of sexual violence from childhood to adulthood survey (IVSEA), conducted in 2015 with more than 1200 victims by the [Traumatic Memory and Victimology](#) NGO, showed that **81% victims were sexually abused for the first time before the age of 18, 51% before the age of 11, and 23% before before the age of 6.**

2- Denial, law of silence, lack of protection and recognition

Child sexual abuse is particularly frequent, yet it still remains largely underestimated. Denial and the law of silence still rule. The vast majority of child victims of sexual abuse are not identified, although they are the main and most important victims of such serious crimes (68% of rapes in the IVSEA survey). Less than 20% report having been recognized as victims and protected, and only slightly more, 30%, among those who filed a complaint (IVSEA, 2016).

[Children are all the more trapped, silenced and abandoned](#) as 94% of these acts of violence are committed by relatives and 54% by family members. Abusers - mostly men, a quarter of whom are minors - almost always enjoy complete impunity. Children are a prime target of sexual predators who always operate in contexts characterized by inequality, male dominance and denial of rights. The child victims are vulnerable, defenseless, dependent and subject to the authority of adults. It is easy to manipulate, threaten and silence them. The more vulnerable children are (children with disabilities, discriminated against, foreigners), the more they experience violence and the less they are protected. Thus, the risk for a disabled child to experience sexual abuse is four times higher. In order to protect a child, we need to know to know if she/he undergoes violence, and for that, we need to ask questions instead of waiting for the child to speak. Indeed, a child is rarely able to speak, especially when the abuse is committed by relatives.

3- Ignoring the heavy impact of sexual violence on children's health

The seriousness of the psychotraumatic consequences of sexual abuse on children's health is still largely unknown and unacknowledged, and so are the social consequences on the child's learning, cognitive, socialization abilities, the risks of asocial behavior and delinquency, and the risks of becoming a victim of abuse again, or to become an abuser (the WHO acknowledged in 2010 that the main cause of experiencing or committing violence is having already experienced it).

[Sexual abuse is one of the worst traumas](#), and almost all child victims develop [psychotraumatic disorders](#). These traumas are not only psychological but also neurobiological in their nature, with cortical attacks and alterations of the emotional and memory circuits that cause dissociation, [traumatic memory](#), neurovegetative hyper-reactivity, and survival strategies: avoidance, control, and risk taking behavior.

While for all-causes-confounded traumatic exposure (abuse, violence, accidents, natural disasters, violent death of relatives, etc.) the risk of psychotraumatic disorders (posttraumatic stress disorder) is of 24%, in case of physical abuse and violence within families, and for children witnessing violence, the risk of psychotraumatic disorders increases to 50 or 60% (Astin, 1996). In case of sexual abuse or acts of barbarity, this risk increases to over 80 % for adults (Breslau, 1991) and to nearly 100% when it comes to child victims (Lindbeg, 1985).

Psychotraumatic disorders are a universal and normal response found in all the victims in the days and weeks that follow trauma (McFarlane, 2000). **They settle in for a long term, for many years, unless something is done to protect and treat the victims.**

Without being recognized and cared for, those severely traumatized children develop extraordinary strategies to survive abuse, violence and their own traumatic memory which - like a horrible time machine, goes back in time and makes them relive again exactly what they underwent, in an endless torture. Their survival strategies (avoidance behaviors and dissociative risk behaviors) are disabling and cause frequent traumatic amnesia (38-40%).

[The long-term health consequences](#), all the more serious as victims have been raped, are younger than 11, and the perpetrator is a family member, concern [early death risk](#) by accident, illness and suicide (according to the survey one out of two victims attempted suicide), anxiety-depressive disorders (50% of victims go through depression, anxiety, panic attacks,

phobias, obsessive disorders), addictions (50% of victims) , major cognitive disorders, stress-related diseases: [cardiovascular](#) and respiratory diseases, diabetes, stunting, obesity, epilepsy, immunity disorders (infectious and autoimmune diseases: multiple sclerosis, rheumatoid arthritis, Crohn's disease, ulcerative colitis), endocrine disorders (thyroid and pituitary disorders), allergies, otolaryngology and gynecological disorders (dyspareunia, uterine fibroids, endometriosis, ovarian cysts, papillomavirus), urinary infections, digestive disorders (chronic constipation, gastritis, functional colopathies) and eating disorders (bulimia, anorexia), dermatological conditions (psoriasis, eczema...), chronic pain (migraines, osteo-articular pain, fibromyalgia), sleep disorders, chronic fatigue, as well as a greater risk of developing cancers. One in five pregnancies from rape concerns a minor. A majority of prostituted women have experienced sexual abuse as children.

For 96% of the participants in the IVSEA 2015 study, their sexual abuse as children affected their mental health, and for 69% of them, it impacted their physical health.

Having experienced abuse as a child is the [main health determinant even 50 years later](#) (American prospective study of Felitti and Anda, 2010) and [can bring a loss in life expectancy of up to 20 years](#) if several types of abuse are associated (Brown , 2009).

When they face a child who is suffering, suicidal or in danger, the professionals' lack of training means that few of them question what is hidden in this distress and ask her questions about whether she suffers of has suffered from abuse (a question that should be systematic during any interview). The children's psychotraumatic symptoms are frequently ignored, minimized, trivialized, attributed to the adolescent crisis or, conversely, labeled as behavioral or personality disorders, or even as autistic or psychotic disorders as if they were not linked to the abuse. Some children may be mistakenly diagnosed with mental retardation and severe developmental disorders. The proposed treatments are most often symptomatic and dissociative, the aim being to anesthetize the mental pain with sometimes heavy treatments that associate antidepressants, neuroleptics, mood regulators, etc.

For the victims, the non-recognition of their psychotraumatisms is a loss of opportunity because a specific psychotherapeutic treatment would allow to treat their traumatic memory, to no longer be colonized by [abuse and perpetrators](#), to activate a neurological repair and to avoid long term consequences on health.

4- However, a solid literature based on clinical and neurobiological studies is available

Numerous clinical and neuro-biological studies have consistently shown for more than 10 years that sexual abuse impacts the victims not only psychologically, but also neuro-biologically, by producing neurological circuit disorders and disrupting the endocrine responses to stress (McFarlane, 2010). These effects have been well documented. They leave MRI-visible cerebral sequelae, a decrease in the activity and the volume of certain structures (decrease in the number of synapses), and a hyperactivity in others, as well as an impaired functioning of the memory circuits and the emotional responses. Recently, epigenetic alterations have also been found in victims of child sexual abuse, such as the modification of a gene (NR3C1) involved in controlling the stress response and the secretion of stress hormones (adrenaline, cortisol). Such epigenetic alterations that can

be transmitted to the next generation (Perroud, 2011).

Even more recently, a study conducted by an international research team from Germany, the United States and Canada published in June 2013 in the American Journal of Psychiatry (Heim, 2013) has highlighted anatomical changes in the brain visible by MRI in some cortical areas of adult women who had been victims of child sexual abuse. Remarkably, the cortical areas that have a significantly decreased thickness compared to those of women who have not suffered abuse, are those that correspond to the somatosensory areas of the body parts affected during the abuse (genital, anal, oral areas etc.). The thickness of these cortical areas is all the more diminished as the sexual violence was more serious (rapes, several abusers).

Those numerous studies have already made the link between the neurobiological findings and the clinic of psychotraumatism. The understanding of the link is based on a theoretical model (Shin, 2006, Yehuda, 2007, Salmons, 2008 and 2012) that explains the mechanisms (a model can not pretend to explain reality in its whole). I participated in the elaboration of this model, which allows to describe the brain neuro-biological mechanisms at work during abuse and violence, and to explain in a coherent way the various psychotraumatic symptoms which otherwise seem paradoxical and are difficult to understand.

II. THE PSYCHOTRAUMATIC IMPACT OF SEXUAL VIOLENCE MADE TO CHILDREN

1- The psychotraumatic mechanisms

Violent events produce a traumatic memory of the events, which is different from the regular autobiographical memory and is a central symptom of psychotrauma. The traumatic memory is a non-integrated memory that remains trapped in specific brain structures. The mechanisms that produce such traumatic memory can be viewed as **exceptional safeguarding mechanisms triggered by the brain to escape from the vital risk represented by an extreme emotional response to trauma.**

The mental stupor (*sidération*)

Sexual abuse and violence are terrorizing and incomprehensible to children. They create a mental break-in that provokes **a state of stupor (*sidération*).** Children become psychically and physically paralyzed, petrified, unable to react, scream, defend themselves or flee. This blocks all and any mental representation and prevents any possibility of controlling the major emotional response triggered by an archaic subcortical survival brain structure: the **cerebral amygdala**. The *sidération* is even more important if the child is young and unable to understand what is happening.

The cerebral amygdala is similar to an alarm siren that automatically turns on during any threat situation (visual, auditory, sensitive, or emotional threat), even before the situation is identified and understood as such by the higher brain functions. Its function is to alert and prepare the body to respond to danger, fight or flight. It can be

activated in the fetus from the 3rd pregnancy trimester, in the newborn from birth, and even if the victim does not have the ability to intellectually understand what happens to her (for example, in very young children, children with severe mental handicaps, children who are unaware of the danger: asleep, under drugs, etc.). This means that, while the abuse scene staging can mislead the victim's higher brain functions (her abilities to analyse, understand and memorize), the danger itself, and the abuser's intention to harm, are perceived by the cerebral amygdala regardless of how the abuse is staged.

The cerebral amygdala triggers an emotional response a hypervigilance and a release of stress hormones, adrenaline and cortisol, that provide the body with the "fuel" needed for the body to face danger (oxygen and glucose). Like any alarm siren, for safety reasons, the amygdala does not turn off by itself. It can only be modulated or turned off by the cerebral cortex and the hippocampus (the operating system for memory, learning, and temporal-spatial mapping), thanks to the mental representation and the previous experience of similar situations (integration, analysis and understanding of the situation, decision-making).

The disruption of the emotional circuit

During violence, stupor (*sidération*) paralyzes the cortex and makes it incapable to modulate the amygdala "siren" which thus continues to "scream" and to release a large quantities of stress hormones. The body is in a state of **extreme stress**, with **levels of stress hormones** that rapidly reach a toxic level **that bring a vital cardiovascular (adrenaline) and neurological risk (cortisol is neurotoxic)**. To escape such vital risk, as in an excessive electrical circuit in which the circuit breaker may trip to protect the electrical devices, **the brain causes the emotional circuit to trip by means of neurotransmitters, which are anesthetic and dissociative "hard drugs"** (morphine-like and ketamine-like, endorphins and NDMA receptor antagonists).

Dissociation and the traumatic memory

This disjunction isolates the cerebral amygdala, by thus extinguishing the emotional response and mitigating the vital risk by creating a state of emotional and physical anesthesia. The amygdala, however, stays on for as long as the danger persists, but it remains isolated from the rest of the brain. Its disjunction causes **traumatic dissociation**, a consciousness disorder related to the disconnection from the cortex, which causes a sensation of unreality, of strangeness, of absence, and which gives to the child victim the feeling of being a spectator of events, as if she was watching a movie. In addition, such disjunction also isolates the cerebral amygdala from the hippocampus (another brain structure, a kind of software that manages memory and temporal-spatial mapping, without which no memory can be memorized, remembered or temporalized). The hippocampus can not do its job to encode and store the sensory and emotional memory of violence, and thus these memories remain trapped in the amygdala without being processed, nor transformed into autobiographical memory. They remain out of time, non-conscious, identical, unintegrated, likely to invade the field of consciousness and relive the hallucinatory scene again, like a machine to go back in time, with the same sensations, the same pain, the same sentences heard, the same smells, the

same feelings of distress and terror (flashbacks, reminiscences, nightmares, panic attacks ...). **It is this memory trapped in the amygdala that has not become autobiographical, which is called traumatic memory.**

The disjunction occurs all the more quickly that the stupefaction is important and that the higher functions are deactivated or immature (very young children, children asleep, drug addicts, with mental or sensory handicaps). The trauma will then be all the more massive.

2- Traumatic dissociation

The child is then disconnected from her emotions and stress. Suddenly, she falls into a state where everything seems unreal, external to herself, as if she were a spectator: she is emotionally and physically anesthetized, and seems to stand everything. Her traumatic dissociation persists as long as she is confronted with the abusers, with the abuse context, or with her deep incomprehension of her experience of the abuse.

During dissociation, the amygdala and the traumatic memory trapped inside are disconnected, and the victim has no emotional, nor sensory access to traumatic events. This dissociative state anesthetizes and prevents her from identifying and getting the measure of the abuse. The most serious abusive facts seem to her so unreal that they lose all consistency, as if they did not really exist. Depending on the intensity of her dissociation, she may be amnesic of all or part of the traumatic events, with only a few remains of fragmented images, fragments of invading emotions, or isolated details. **This traumatic amnesia is very common among victims of child sexual abuse** (nearly 60% of child victims have partial amnesia and 40% total amnesia, cf. Brière, 1993, Williams, 1995, Widom, 1996, IVSEA, 2015). This phenomenon can last for many years, even decades.

Therefore, the dissociated victim remains indifferent not only to the continuation of the abuse, but also to her traumatic memory of those that she has already suffered. Still, her traumatic memory is activated immediately after the trauma, by any cue (situation, sensation, confrontation with the abuser, etc.) that reminds the traumatic events. It then invades her *psyché* but without any emotional feeling, which makes it unreal, disembodied, indistinct, lost in the midst of all mental representations. The sensory and kinesthetic perceptions (images, smells, sounds, bodily sensations) stored in the traumatic memory are disconnected from their emotions - distress, terror, disgust, etc. The events “are there”, but seem far away, as if they were in a fog, they do not impose themselves emotionally, resulting in the victim seeming indifferent to abuse and tolerant to suffering.

This is not to say that the abuse and its reminiscences become less stressful and traumatic, in fact it is quite the contrary, because of the victim’s lack of self-defense and protection reflex (in a similar situation, when we put an anesthetized hand on a hot electric hob, we still get badly burned even though we feel no pain).

Traumatic dissociation is a veritable mental hemorrhage that empties the victim of all her desires, and annihilates her will. The dissociated victim feels lost, has a feeling of strangeness, she does not recognize herself anymore. She is deprived of her emotions, disconnected from herself and from the outside world, unable to think what is happening and to react to it in an appropriate way. She is on automatic mode, with a sense of absence from

the world, of being cut off from herself and her body. She is indifferent to danger and pain. The dissociation encloses the victim in a mental space out of time, where the future has no reality.

Such dissociation makes it very difficult or impossible to oppose any mental and physical defense to the abuse against her: the murderous words, the punches, the humiliations meet no resistance. This makes the victim very vulnerable to the abuser, who can exercise total control over her, colonize her psyche, reduce her to slavery, and quietly subject her to all the abuse he wants, as if she were a puppet, sometimes for many years. The abuser can physically subjugate her, enslave and psychologically colonize her to make her do and think what he wants, and make her feel guilty, worthless, without any right, an object at his disposal.

Victim dissociation is a major risk factor for revictimization and for being placed under an abuser's psychological control (*emprise*) (70% of victims of sexual violence experience further sexual violence throughout their lives, IVSEA, 2015). Predators prefer to target a person who has already been dissociated by previous violence, most often in childhood, which guarantees them both impunity and the possibility of practicing limitless abuse. Dissociated people, especially children, are frequently perceived as bizarre, masochistic, or having a mental pathology (psychosis, autistic disorder, ...).

In addition, the dissociated child is often thought to be intellectually limited, "stupid", unable to understand and react to what is happening, mocked, humiliated and abused by everyone. The child risks harassment and other further abuse. The movie *Polisse* shows such a scene in which a young teenager who was forced to oral sex with several boys to recover her mobile phone. She seems so indifferent to the situation that the police allow themselves to lecture her and even make fun of her by asking her the question: "What would you have done if they took your laptop?". And the police burst out laughing, just like the movie spectators... They make fun of a severely traumatized victim.

Dissociated victims are easy preys for predators. Their confusion and disorientation due to dissociative symptoms lead to cognitive disorders and permanent doubts about their own perceptions and memories of what they heard, what has been said and what is understood, which make them vulnerable and unable to defend their convictions and wishes. Disconnected from their frontal cortex (the area involved in analysis and decision-making) and their hippocampus (the operating system of memory and learning), the dissociated victims are influenceable and "hypnotizable". It is very difficult for them to say "no". They often proceed on an automatic, pre-programmed mode. They have no confidence in themselves, and when they are put under pressure, they find themselves giving in to the desires of others in spite of themselves. The more dangerous the interlocutor is, the more he will awaken in his chosen victim her traumatic memory and dissociation by his inappropriate or incongruous attitudes and words, by staging his domination, and putting the victim in a hypnoid state that disables her thinking, defending, opposing and refusing. Victims think that such a state of incapacity is due to their stupidity, their inferiority or their morbid timidity, whereas it is directly related to the triggering of safeguard mechanisms against the danger that represents the interlocutor. Such mechanisms, however, could be good warning signs if the victims were informed and learned how to recognize them as such. Instead, their interpretation of a dangerous situation gives an advantage to the perverse interlocutor. The

latter is often perceived by the "hypnotized" victims and their entourage as someone superior and important, fascinating, much more intelligent than themselves, of a different essence, with whom they may even think they are "in love", while they are not and they are just terrified and actually under control, because of the dissociation mechanisms.

Dissociated victims are easy preys for pimps. Young girls who have been sexually abused in childhood by relatives, with whom they most often live, are severely dissociated. Because of this dissociation, they are sought by pimps and particularly appreciated by clients because they tolerate sexual abuse, painful and humiliating practices, and abuse against their physical, mental integrity, and dignity, without the ability to oppose and revolt, even with a smile. Among people in prostitution situations have a history of abuse with multiple forms of violence, most often since infancy: 59% maltreatment, 55% to 90% child sexual abuse (see Mélissa Farley's 2003 study conducted in 9 countries with 854 prostitutes; these percentages are corroborated by many other studies). The percentage of sexual abuse among prostituted persons is extremely high, and the link between child sexual abuse and entry into prostitution is very significant.

Thus, the child seems indifferent to abuse, but she will not be less traumatized.

A dissociated victim runs a great risk of not being detected, nor protected. While everyone has the innate ability to perceive the emotions of others, through mirror neurons, no emotional feeling is sensed in front of an anesthetized person; it is only intellectually that the suffering of this person can be identified. Relatives and professionals, who do not understand the victim's dissociation, react toward her with a lack of empathy, minimize the child abuse and her suffering, do not believe her and even question her words and the reality of the abuse.

A dissociated victim runs a high risk of not being believed, nor recognized in court. Dissociated victims do not have the behavior "expected" of a victim. They are in a state of disconnection such that they are unable to speak or complain, sometimes for years if they stay in contact with the abuser or in the context of the violence. Reproaches are made to them for waiting too long, which fuels doubts about their good faith.

Their traumatic dissociation makes their accounts bitty, they have permanent doubts about what happened and a feeling of unreality, many episodes are struck by amnesia, and because of the hippocampus disconnection, they find temporo-spatial locations very difficult when it comes to the dates and places where the abuse occurred. The more their interlocutor is incredulous or annoyed, the more they are dissociated and lost.

Similarly, the victims' confrontations with the abusers aggravate their dissociation and massively re-traumatize them: they lose their capacity even more, are invaded by a feeling of unreality, easily find themselves under the abuser's influence, and may call into question, or even retract, what they had said before.

3- Traumatic memory

The traumatic memory is set up with the disjunction. As we saw, it is an emotional memory of the abuse, which stays trapped in the cerebral amygdala, and which could

not be processed by the hippocampus because of the amygdala's disconnection from the hippocampus under extreme stress conditions. The hippocampus is a brain structure that integrates and transforms emotional memory into an autobiographical, verbalizable memory. Like a software, the hippocampus is essential for storing and retrieving memories, learning, and situating oneself in time and space. Because of the disjunction, these functions are seriously disrupted.

Traumatic memory is thus an encysted emotional memory, a hypersensitive and uncontrollable "ghost" memory, ready to "explode" and to make the victim revive the violent event, experience it identically again, with the same emotions, sensations, fear, and distress that are attached to it, like a machine to go back in time. It "explodes" as soon as a cue, such as a situation, an affect or a sensation, etc., recalls the memory of the abuse or makes the victim fear that violence will happen again. Traumatic memory is like a "time bomb" that can explode often months or even years after the violence. When it "explodes", it invades the victim's entire mental space uncontrollably. It transforms her mental life into a minefield. Just like a "black box", it contains not only the victim's emotional, sensory and painful experience, but also all that relates to the violent facts, their context, and the abuser (his mimicry, his staging, his hatred, his excitement, his screams, his words, his smell, etc.).

However, as long as the child victim is dissociated, her dissociation anesthetizes the emotions and pain brought back by the explosion of her traumatic memory. She seems, then, not to suffer and tolerate them. In fact, they aggravate the traumatic impact, and will charge the traumatic memory even more, like a pressure cooker.

When the victims emerge from their dissociated state, their traumatic memory comes to be felt without the filter of dissociation and this will be intolerable.

The victim's dissociation may disappear either when she is finally secure and no longer permanently faces abuse, the abusive context, or her abuser, or when she gets out of her state of incomprehension and confusion by growing up, retrieving information, therapy, or facing a sexual context, pregnancy, or additional violence. Traumatic memory then imposes itself with such an emotional load that the seriousness of the abuse and the gravity of its consequences suddenly appear to the victim in all their horror. The victim may then face a real tsunami of terrifying emotions and images sweeping into her, together with great suffering and distress. It is a real torture. This can lead to a state of panic and fear with a feeling of imminent death, agitation, intolerable anguish, excruciating pain, and a state of confusion. These symptoms are so impressive that the victim may end up in medical or surgical emergencies (she may even go through surgery on an emergency basis) or be hospitalized in psychiatry (often misdiagnosed with delirious flushing or schizophrenia), and this state is frequently accompanied by a very important suicidal risk, especially if the victim faced a murderous intentionality, she revives this intentionality as if it came from herself, in a compulsion to kill herself.

It is at this point that the victims emerge from their "pseudo-indifference" and dissociative traumatic amnesia, and they can finally start to realize the seriousness of what they have suffered and to denounce the violence. This dissociative state exit may

occur several years, or even several decades after the events, while the facts are prescribed.

Many cues are likely to trigger a victim's traumatic memory: a specific date, a time of the day, a place, a situation or small details (an odor, a taste, a sound, a word, objects, elements in a room's decor, colors, blood) that recall the abusive context, a moment of stress or fear, a medical examination, pains, cries, sensations and emotions (reminiscent of those felt during the violence), return to the place where the abuse occurred, facing the abusers or their accomplices, etc.

Traumatic memory is often responsible not only for feelings of terror, distress, imminent death, pain, unexplained feelings, but also for feelings of shame and guilt, and catastrophic self-esteem fueled by the abuser's words stored in the victim's traumatic memory, his gestures and stagings, his hatred, scorn, perverse excitement. In the victim's traumatic memory, everything is mixed with no identification, sorting out, nor control. During the abuse, this undifferentiation prevents the victim from making a separation between what comes from her and the abuser, and it is possible for her to feel both the terror, which is hers, and a perverse excitement and enjoyment, which are those of the abuser. Similarly, it is impossible for her to defend herself against the abuser's mocking and murderous sentences of the: "you like it", "that is what you want", "this is what you deserve", which will be stored and stay trapped in her amygdala even long after the abuse.

For example, when her traumatic memory "fires", a child who has been abused before she learned to speak may find herself unable to speak, and only able to cry, even ten years later. Likewise, a child who has suffered sexual abuse in the dark, when her traumatic memory "fires", may well see nothing; a child who was attached may become unable to move, a child strangled or suffocated by oral penetration may be unable to breathe. In addition, since traumatic memory traps not only the victim's experience of the abuse, but also the abuser's experience and words, the child may hear, even many years later, sentences pronounced by the abuser such as "you are worth nothing", "You are bad", "you do not deserve to live", etc. This mechanism explains why children feel so guilty and have such attacks on their self-esteem: they are permanently colonized by the abusers via their amygdala and their traumatic memory.

It also explains that when children are very young (before 6-7 years old) and / or when they are very dissociated, deprived of their emotions and that they have not yet sufficient mental representations of what is forbidden, they can, during their traumatic memory ignition, re-enact scenes of sexual abuse that invade them both from the victim side as well as the abuser side, and have inappropriate sexual behavior in public: undress, expose their sex, masturbate, put objects in sex, touch adult sex, rub, say hypersexualized or abusive sentences, or even sexually abuse other children. These behavioral disorders must immediately alert, as they sign a sexual trauma.

It must be reminded that a fetus, a newborn, a traumatized infant, a child who is unaware of the abuse because she is asleep, drugged, too young or too intellectually handicapped to understand the abuse, can all develop a traumatic memory, even if she cannot remember the abuse in an autobiographical way (the hippocampus only becomes functional for the autobiographical memory after the age of 2-3 years old).

In the end, traumatic memory transforms the victim's life into a minefield and a real torture. One can not live with a traumatic memory. Thus, if the child's traumatic memory is not treated, she is condemned to put in place strategies that are essential for her to survive, but also seriously handicapping, and often laid against her.

In sum, either the traumatized child is dissociated, and then she no longer feels her traumatic memory even if she continues to be abused, or if she stays in contact with the abuser and the violent context. Or she is secure, for example at school, or later when she no longer is in contact with the abuser and his system, and then her traumatic memory invades her. For example, while at school, her traumatic memory may express itself through panic attacks, a great distress, but also through verbal or physical violence (when she is invaded by the abuser's violence).

4- Traumatized children's survival strategies

When victims are abandoned with no protection, nor solidarity, nor support or (which is the case for 83% of victims in the IVSEA survey, 2015), they are condemned to implement disabling and exhausting survival strategies.

1. During the abuse, and as long as the traumatized child is exposed to the abuser, three main mechanisms are put in place to survive:

- **escape**: on the rare occasions when it is possible, it often represents a great danger for the child. A child's run away, or a teenager's early departure from their home environment, should always call for a search for abuse or violence as a cause.

- **a coping mechanism**: to avoid the occurrence of abuse and the risk of rejection and abandonment, traumatized children hyper-adapt to their abusers and to do so they identify with them, they learn to perceive and anticipate the slightest changes in their mood. They become true scanners, able to decrypt and anticipate the needs of their perpetrators. For those children, it is essential that their perpetrators never become upset or frustrated, so they have to know them perfectly and to pay permanent attention to what their perpetrators do and think. This phenomenon may give the traumatized children a feeling of being very attached to their perpetrators, since the latter take a place in the children's own head (Stockholm syndrome). Traumatized children may believe that their abusers matter more than anything to them (this is what the perpetrator constantly reminds them of: "I am everything for you, without me you are nothing ..."), and that what they feel for their perpetrators is love, whereas it is an adaptive reaction to a situation that puts them under terror.

- **a neuro-biological protection mechanism automatically triggered by the brain when it faces extreme stress and intolerable situations: traumatic dissociation**. As long as danger lasts (abuse or violence persist), as long as the risk of its recurrence exist (the traumatized child is in contact with the abuser or with the violent context), as long as the danger was not identified (the child did not realize what happened because she was too young, unconscious at the time of the violence: drugged, alcoholic, asleep, or manipulated) the

cerebral amygdala stays on and loud permanently, which consistently disrupts the emotional circuit in order to protect the vital organs that are the brain and the heart, and consistently causes a traumatic dissociation of the victims. The traumatized children are then disconnected from their emotions, emotionally anesthetized, thus have a greatly increased pain threshold. They find themselves operating on an automatic mode, as robots, detached from themselves, as if they were spectators. This leads to a pseudo-tolerance to the intolerable: "look, there is no pain!" As long as the victim's dissociation lasts, the abusive situation seems unreal and it is very difficult for the traumatized children to identify its seriousness. Moreover, when the traumatized children face the abuser or any other person, their traumatic dissociation makes them appear as indifferent to their own fate, inert, since they are cut from their emotions. While allowing the abusers to not be bothered by the distress signals from their victims, the traumatized children's dissociation is very dangerous for the children because the violent acts against them can become more and more extreme, as they are unable to respond (however, their emotional anesthesia will not prevent them from being even more traumatized). Similarly, the relatives do not easily detect the traumatized children's distress and suffering, and neglect them even more. Finally, as we have seen, dissociation is an important risk factor for the children's subsequent mistreatment and scapegoating.

2. After the violence, when the traumatized children are no longer confronted with the abuser, and when they become able to understand, they come out of their permanent dissociative state, but, as we have seen, their traumatic memory takes over and they continue to be colonized by the violence and the abuser as soon as a cue recalls them (a place, a situation, a sensation, an emotion, etc.). It becomes then suddenly unbearable and it can give the impression of falling into madness, which is often experienced by the victims as even worse than their previous state of dissociation. If they do not have the right explanations about the mechanisms that trigger this process, they may be tempted to return to the abuser or reconnect with the violent context (such as an incestuous family, prostitution, or dangerous dating). Traumatized victims, then, feel that they must avoid at all costs their own traumatic memory, because of the anxiety and pain that it triggers. Two strategies are then possible:

- To avoid the frightening effects of triggering her traumatic memory, the traumatized child puts in place control and avoidance strategies towards everything likely to "ignite" it (hence, separation anxieties, regressive behaviors, intellectual withdrawal, phobias and obsessive-compulsive disorders such as repeated washing or constant checks, intolerance to stress). She frequently creates a small secure parallel world where she feels safe, which can be either a physical world (such as her room, surrounded by objects, stuffed animals, or animals that reassure her), or a mental world (a parallel world where she takes refuge continuously). Any change is perceived as threatening because it jeopardizes the landmarks that she set up, therefore she adopts hypervigilance behaviors – which come together with a feeling of fear, alert, and permanent danger, hyperactivity, irritability and increased attention. These avoidance and hypervigilance behaviors are exhausting and invasive. They lead to cognitive disorders (attention, concentration, and memory disorders), which often have a negative impact on learning, at school, etc.

But traumatized children are often thwarted in their avoidance and control behavior by an adult world that understands nothing of what they feel. Many adults feel that traumatized children must empower themselves and expose themselves to whatever scares them the most, such as being separated from a parent or protective adult, sleeping alone in the dark, facing unknown situations and even an abuser or someone who looks alike, etc. **When a traumatized child is unsecure and cannot set effective avoidance behaviors, her traumatic memory explodes frequently, which plunges her each time into great distress until she dissociates again by disjunction.** However, because of its habituation to the dissociative drugs secreted by the brain, her emotional circuit is less and less able to trip off, which generates an even more intolerable distress, which can only be calmed, or prevented, by further risk taking behaviors that finally produce dissociation.

- Such **risk taking behaviors that lead to dissociation** are something that traumatized children and adolescents experiment quite quickly to produce a disjunction "at any cost", switch off the emotional response by anesthetizing it, and so to **calm down a state of intolerable tension, or prevent it from occurring. This self-induced disjunction can be obtained in two ways, either by causing a very high stress** that increases the quantity of dissociative drugs secreted by the body, or by using dissociative drugs (alcohol, narcotics).

Examples of such dissociative risk taking behaviors are self-aggressive behaviors (hitting, biting, burning, scarifying, trying to commit suicide), **self-endangerment** (dangerous driving, dangerous games, extreme sports, risky sexual behavior, prostital situations, running away, dangerous encounters), **addictive behaviors** (alcohol, drugs, or medicines consumption, eating disorders, addictive games), **delinquent and violent behavior against others** (the others, then, serve as a fuse on which the traumatized child imposes her power in order to self-disjunct and anesthetize herself).

Risk taking behavior is therefore a deliberate self-endangerment. It consists of an active or even compulsive search for situations, behaviors or substance use known to be dangerous in the short or medium term. **The risk is sought for its direct dissociative power** (alcohol, drugs), for the extreme stress that it brings (dangerous games, scarifications, ...), **and its ability to trigger the safeguard disjunction that disconnects the emotional responses, which leads to emotional anesthesia and dissociation.** However, risk taking behavior also reloads the traumatic memory, making it ever more explosive, and making dissociative behavior ever more necessary, by thus creating a real addiction to self-endangerment and / or violence. Dissociative behavior is incomprehensible and seems paradoxical to everyone (the victim, her family, professionals). It makes the victim feel guilty and lonely, which makes her even more vulnerable. It can lead to permanent dissociation, as during the violence, characterized by an apparent detachment and indifference that decreases even more the traumatized child's chances to be rescued, and makes her even more ignored and abused.

Dissociative risk taking behavior serves to provoke "at any cost" a disjunction and extinguish the emotional response by anesthetizing it. It must be understood that a traumatized child finds it better to scarify or endanger herself to anesthetize herself, than to relive the abuse and extreme violence that she has suffered. While her behavior may seem incomprehensible, it is, on the contrary, very logical. It is also very important that the

traumatized children can understand this logic, and the mechanisms at work. Otherwise, they have the feeling that they are weird, different from others, unable to be like the others. Children should be informed of the psychotraumatic consequences of abuse, so that they can understand what they feel, and therefore better manage and defuse their traumatic memory, as well as to reassure themselves about their « normalcy ».

3. Because of these survival strategies, a victim of child sexual abuse can, in adolescence and adulthood, oscillate between:

- an impossible or a very difficult sexual life with a loved person, because most gestures and sensations of a sexual act (tactile, olfactory) cause traumatic reminiscences that make them unbearable, very distressing, generate rejection and impossible to overcome disgust feelings, intolerable pain (pelvic pain, dyspareunia, vaginismus, cystitis, lumbar pain, but also in case of oral sexual abuse, very painful contractures of the jaw, incoercive nausea, vomiting). This makes sexual intercourse only possible when she is dissociated (by drugs or alcohol, or after bringing on herself extreme stress, by means of violent mental images). It can also lead to her avoiding any gynecologic, anal, stomatologic or dental examination.

- in times of great ill-being, in order to dissociate, the victims may use sexual risk taking behavior, such as unprotected sex with strangers, violent sexual acts (self-aggressive, "somasochistic" practices), self-endangerment on the internet, or with obviously perverse people, self-aggressive and violent compulsive masturbations, self-inflicted sexual wounds, scarification, or even prostitution practices.

Moreover, the victims' quasi-permanent dissociation gives them the painful impression of not being themselves, having a false self, as if they were actors in a permanent staging. Their emotional anesthesia forces them to "play" emotions when they face other people, with the risk of either not being quite in phase with those others, or to over- / underplay emotions.

Self-harm, suicide, revictimization risk, and violence reproduction risk

Traumatic memory and dissociative behavior can lead to life-threatening risks, with a ten-fold increase in suicide rate and early death (by self-endangerment). In the AIVI (the International Association of Victims of Incest) and the IVSEA (2015) surveys, nearly 50% of victims of child sexual abuse have made suicide attempts.

While some suicide attempts may be related to a conscious willingness to end a life of suffering, most are due to the traumatic memory of the abuser's destructive and criminal will, which invades the victim's mindspace and can make it suddenly switch to a suicidal act, in an acting out. The victim, then, reproduces either the abuser's past murder attempt against her, or his injunction staged as "you are worthless, you are nothing, you do not deserve to live, you are unworthy, you are a garbage that is only good to throw, etc.". The victim is colonized by the abuser, his murderous desire imposed on her as if it came from her own thoughts. This injunction is intolerable for the victim, and responding to it by suppressing herself in a

dissociative compulsion becomes the only solution for her to escape the scene and to extinguish the violence that explodes inside her mind.

Because of the risk taking dissociative behaviors, leaving the traumatized victims without care increases the likelihood of reproducing violence, both from one person to another, and from generation to generation: indeed, the victims are at significant risk for being subject to abuse and violence again, and also to commit violence, first of all self-directed, and for a small number of them, directed against others, all of which is enough to fuel an endless cycle of violence. The WHO recognized in 2010 that the main factor to suffer or commit violence is to have already suffered.

Reproducing the violence we have experienced on children is terribly effective to anesthetize emotionally and crush the little victim that we have been and that we despise. Switching to a fully powerful position, then, allows us to escape our traumatic memory, terror and permanent fear. This is a dissociative strategy. But if, when a traumatized person is left abandoned without care, nor protection, she not be held responsible for being invaded by her traumatic memory that revives violence, nor for putting in place survival strategies such as avoidance, control and / or dissociative behavior. On the other hand, however, one *is* responsible for the choice that one makes to use such behavior *against others*, and one's use using of others as a fuse to trip off.

When the victim's traumatic memory of the abuser's hatred returns to haunt her with his scorn and perverse excitement, the victim can bravely fight to relentlessly control what she thinks to be her own demons. Obviously, they are not hers: they are intrusive traumatic recollections that invade her, and she is unable to identify them as such. They appear as compulsive phobias, with fears of acting out. The traumatized victim fights to control them by self-censoring and avoiding all situations that may trigger intrusive images or sensations (such as sexualized situations, being with children, touching them), or she may return such intrusions against herself and to self-hate, self-despise and sexually self-harm in order to disjunct and anesthetize. Or, she can become one with those intrusions, identify with them and act on others by reproducing the act perpetrated on her by her abuser, which will also allow her to disjunct and anesthetize, with a bonus of omnipotence and the risk of a real addiction to sexual violence. For a child it is difficult to fight those incomprehensible invasions, but for an adult the choice not to act out on others, not to violate the laws, not to despise the victim's rights and suffering is always possible, although at the price of a whole arsenal of constraints **(while we are not responsible for the violence that we have suffered, nor for its psychotraumatic consequences, we are, however, responsible for the survival strategies that the we choose when they undermine the integrity of others).**

Moreover, it is obvious that precisely because the children have been abandoned with no protection, nor appropriate care, they have to deal with their terrible traumatic memory which forces them to self-censor incessantly and live in a permanent war. If their traumatic memory had been treated, as it should have been, its transformation in an autobiographical memory would have freed them from the torture of the violence and perpetrators that are continuously present inside those traumatized children.

Traumatized children, whose lives shattered by violence, are abandoned with no protection, nor care.

All these psychotraumatic disorders (traumatic memory, avoidance and control behavior, hypervigilance and dissociative behavior) produce very important disorders for traumatized children: psycho-motor development disorders; personality disorders; cognitive disorders that lead to difficulties in school and learning disorders, memory issues and sometimes significant amnesia, relational disorders (isolation, high shyness, low self-esteem), anxiety disorders, eating and sexual behavior disorders, sleep disorders, risk taking behavior and even delinquent, aggressive and self-aggressive behavior, a significant risk of suffering further violence. All of this puts their physical and mental health at risk, including a life risk: the risk of dying by accident (related to risk taking behavior, which is the leading cause of death in adolescents) and suicide (second cause of death in adolescents).

The psychotraumatic symptoms are a source of great suffering in children and adolescents victims of violence, and yet they are still, most often, interpreted as coming from the traumatized child, her nature, her sex, her personality, her ill will, her provocations ... Indeed, rather than linking those disorders to their cause, violence, this type of thinking and “rationalization” seek to explain them by convening the adolescent crisis, bad company, the influence of television, internet, etc. or bad luck and fatality or even a deleterious consequence of overprotection: "she has been too spoiled". Such rationalizations can also “call to rescue” mental illness and heredity: "she is like ... her mother, her uncle, her grandmother, etc.". It is with such rationalizations that of children and adolescents suicides, dangerous games, etc., come to be presented as due to contagion or depressions, while the violence undergone by the victims is almost never evoked like leading cause.

Very often, when they face a child in great suffering, who displays behavioral disorders and risk taking behavior, the adults who are supposed to take care of her use moralizing, blaming, guilt-creating speeches: "you must not behave like that, look at the trouble that you do to your parents, after all that we do for you, etc.", instead of wondering what this child may have suffered, and ask her the question that should be systematic:"have you suffered from abuse or violence?"

These children, severely traumatized by violence, had to live under permanent threat, with no rights, with fear in their stomachs, afraid to speak, afraid of provoking the abuser's ire, afraid of being killed, afraid of waking up in the morning, afraid of going back home after school, afraid of meals, weekends, holidays... They had to develop extraordinary survival strategies, self-censor to avoid all situations at risk of escalating into violence, submit to the perpetrator's diktats and stagings, keep silent, dissociate themselves in order to bear the unbearable, and very often to develop an imaginary world where they could take refuge, a world that sometimes could become invading, with an imaginary companion (a doll, a stuffed animal, an animal, a friend). But such strategies have their limits, and children may go through periods of intense despair during which they risk acting out suicide.

Because of this traumatic memory, the victims find themselves constantly reliving the worst moments of terror against their will. In an endless torture, the pain and despair keep coming back, marked by sudden and recurrent sensations of being in great danger, thrown on the floor, crushed, violently beaten, lose consciousness, die, having intense pains, feeling their head or body explode, suffocating. By such sensations, the abuser remains permanently

present in the victim's mind, imposing on her again and again the same atrocious abuse, his murderous sentences, his perverse pleasure to destroy her and his deliberate incitement for her to suffer, his mystifying staging of abuse, his hatred, contempt, insults, and words that do not, in any way, apply to her. The more the violence occurred early in the victim's life, the earlier and the more she is forced to build her *self* with her induced and devastating emotions, feelings of terror, abusive acts and perverse remarks, the more she needs to fight them without even understanding them, all of this while she is confused about where the dividing line stands between who she really is, and what belongs to the abuser in her traumatic memory. Traumatic memory haunts her, expropriates her and prevents her from being herself. Worse even, it makes her believe that she has a double, even triple personality: a normal person (the one who she actually is), a worthless person afraid of everything who only deserves to die (which is the role that the abuser staged for her, and which she ends up internalizing, since it keeps coming back in her mind over and over again), and a culprit person, of whom she is ashamed, who could become violent and perverse, and must be kept under constant control and censored (which is the ever-present abuser's reflection that invades the victim's mind ending up making her afraid because she confuses him with herself).

Exiting denial, protecting and caring for child abuse victims is a public health emergency

Obviously, because the traumatized children were abandoned without appropriate care, neither protected, nor recognized (as a reminder, this is the case for 83% of the victims according to our IVSEA survey, 2015), they need to deal with a terrible traumatic memory that forces them to self-censor constantly, and live in a permanent state of war. Their traumatic memory should have been treated and transformed into an autobiographical memory, which would have freed them from the torture from the violence and perpetrators constantly present in their minds.

The vast majority of children have not been able to talk for years or even decades about the violence they suffered. The self-assessment survey conducted online by our associations on the impact of violence and the post-abuse care asked the sexual abuse victims why they could not speak about the abuse. The answers from over 1200 respondents were the following (ordered by decreasing frequency):

- the difficulty to put words on what happened and to identify it,
- the feeling of guilt ("I thought it was my fault")
- the fear of not being believed
- the impossibility of talking about it because of the suffering that it reactivates
- the fear of the abuser's threats
- traumatic amnesia and dissociation
- the fear of the listener's reactions.

We must help the victims to speak about their experience, and for this we must communicate the reality of sexual violence and its consequences, inform the victims

about the law and their rights, and it is essential to ask them questions. When they do manage to speak, they must be listened to, believed, we must recognize the sexual violence that they have suffered and their traumas, we must protect them, be supportive and provide them with protection, support and care. It is very important to give them information and to explain the psychotraumatic, psychological, and neurobiological mechanisms so that the victims understand what happens with them, so that they can feel guilt free and have a toolbox to help them better understand themselves.

The psychotraumatic symptoms translate into great suffering among victims of sexual violence, and, while they are very well documented in the scientific literature, they are still largely unknown by professionals because of a lack of training for the vast majority of them. Oftentimes, then, professionals interpret a victim's psychotraumatic symptoms as coming from the person herself, her nature, her sex, personality, ill-will, provocations, or are labeled as mental illnesses. The person is thus considered to be the reason of her symptoms and suffering. As stated above, this type of thinking puts suicides, risk taking behavior, traumatic memory explosions and traumatic dissociation down to borderline disorders, depressions, or even psychoses. Sexual violence, then, is never identified as their lead cause, nor its the question: "did you suffer or did you suffer violence?" ever asked.

These psychotraumatic symptoms are normal and universal consequences of violence, clearly not due to the victim's "personality". They can, however, be aggravated by a specific vulnerability of the victim (in the same way in which the consequences of a stab wound can be aggravated by hemophilia): her age, disability, violence history, etc. Surprisingly, although have been well known for decades, consistently proven by a solid international literature based on research studies published in scientific journals, and even visible on MRIs, they remain largely unknown in France, as doctors and other health professionals learn them neither in academic, nor in continuing education: a recent survey among medical students showed that over 80% reported that they received no training on violence, and 95% requested such training to better care for the victims. Thus, the offer for appropriate care is very rare.

There is a tradition in France of underestimating trivializing violence against minors, in both its seriousness and frequency. As we have seen, ignoring the seriousness of the health consequences of violence adds to this tradition. There is also a lack of knowledge about the social consequences of violence on the traumatized children learning and cognitive abilities, their socialization, risk of antisocial behavior and delinquency, and risk for them to be abused again and further or to become an abuser. There is also a stigmatization of behavioral disorders in children and adolescents, disorders that mask an unrecognized suffering, as well as a trivialization of signs of suffering, which are put down to the adolescence crisis, the victim's personality or sex, or, conversely, a dramatization of the victim's psychotraumatic symptoms (such as her traumatic memory and traumatic dissociation) often wrongly labeled and confused with anxious or depressive neurotic disorders, personality disorders (borderline, sensitive, or antisocial personality), or sometimes as psychotic disorders (manic-depressive psychosis, schizophrenia, paranoia, etc.) and abusively treated as such, instead of being appropriately treated as traumatic consequences. Similarly, the avoidance and thought control processes associated with dissociative disorders can be so pervasive in children and adolescents, and result in such a contact and speech inhibition, that they may be mistaken for intellectual deficits, or autistic-like disorders, from

which they are obviously distinct. All these disorders improve as soon as the traumatic memory receives appropriate care.

The ignorance about these psychotraumatic mechanisms, the absence of care, contributes to the victims being abandoned and left to themselves, the non-recognition of what they have suffered, and to making them feel guilty. The victims are then condemned to manage their own protection and survival alone, and they are held responsible for their own misfortunes and therefore responsible for improving themselves.

Providing the victims with appropriate care is essential

The care for victims is essential. Their traumatic memory must be treated. Care-giving professionals should help the victims understand what they have been through, their condition, and make the connections between their symptoms and the violence that they experienced, help the victims out of their stupor by dismantling the abuser system and “setting the world straight”, and by thus to progressively defuse the victims’ traumatic memory, allow its integration into their autobiographical memory, and decolonize the victims from violence and the abuser system.

The victims’ treatment should start as early as possible. Treating their traumatic memory allows its integration into their autobiographical memory, remediates the existing neurological damage, and makes the survival strategies unnecessary.

For the victim, the goal of psychotherapeutic care is to never give up understanding and giving meaning to every symptom. Any symptom, any nightmare, any behavior which she does not recognize as consistent with who she actually is, any incongruous thought, reaction, sensation must be dissected until it is connected to its origin, until the links that allow to put it in perspective with the violence suffered are found. For example, a smell that gives the victim discomfort, nausea or a feeling of imminent vomiting relates to the abuser’s odor, a pain that makes her panic relates to a pain felt during the aggression, a noise that seems intolerably alarming is a noise that was heard during the violence. For example, if during the abuse the rain was falling, the sound of raindrops may be intolerably distressing; a specific hour of the day can be systematically scary or can lead to alcohol intake, bulimic behavior, acting out suicide, self-mutilation, if that was the time of the aggression; when a feeling of irritation, tickling or warmth in the genitals may occur in a totally unsuitable way in certain situations, it can be due to abusive touching against the victim, or violent, very disturbing, unwanted sexual "fantasies", which invade the victim’s mind as traumatic reminiscences of the rapes or the sexual abuse that she suffered...

Psychotherapeutic work consists of helping the victim find the links between the symptoms and her experience of the abuse, reintroduce a mental representation and a meaning for each manifestation of traumatic memory (“meaning-perfusion”), all of which restore the neurological connections that have been damaged and even allow neurogenesis. It is indeed a matter of "repairing" the initial break-in in the victim’s mind, her mental stupor due to the non-representability of the violence. As we saw, that initial break-in produced a mental breakdown that made the brain unable to control the emotional response, which causes extreme stress, a boost, and disjunction, followed by the installation of a dissociation and a

traumatic memory. Such restoration can be done by "revisiting" the experience of violence through psychotherapy and medication, if needed, with the help of a "professional deminer" who can provide the mental security needed when the traumatic memory "explodes", so that this experience can gradually become integrable, because better representable, better understandable, by putting words on each situation, on each behavior, on each emotion, by analyzing with accuracy the context, the victim's reaction, and the abuser's behavior, in order to "set the world straight". Such psychotherapy needs to disassemble the abuser system, to reconstitute the traumatized child's own history by restoring her personality and dignity, by "cleaning" her mind of everything that had colonized and alienated her traumatic memory (the abuser's staging, his lies, his denial, etc.). So that the person who she actually is can freely express herself and simply live again. So that finally the terrorized child is never again alone. "To break down the wall of silence and join the waiting child" (Alice Miller, 1985).

Such advanced analysis conducted during psychotherapy allows the associative brain and the hippocampus to re-operate, regain control over the cerebral amygdala reactions, and encode the traumatic emotional memory into a conscious, controllable, autobiographical memory. In addition, as stated above, such specialized care allows to recover from the neuronal damage caused by extreme stress during trauma, through neurogenesis and the improvement of dendritic bonds, as evidenced by MRI studies (Magnetic Resonance Imaging) (Ehling & Nijenhuis & Krikke, 2003).

Quite soon, the victim starts to do this psychotherapeutic work almost automatically, and allows to secure the mental ground, because during the traumatic memory "ignition" the cortex becomes able to control the emotional response and to calm the distress, with no need to trip off neither spontaneously, nor by dissociative risk taking behavior. The patient, then, becomes her own expert in "mine clearance" and can continue the work herself, as her formerly needed dissociative behaviors are no longer necessary, her traumatic memory discharges more and more, her feeling of permanent danger subsides and, little by little, it becomes possible to decolonize her traumatic memory and regain its consistency, and stop to survive to finally live.

It is therefore essential to protect children from violence and to provide them with specific care as soon as possible, as they are in emergency situations and caregivers need to prevent the setting up of severe and chronic psychotraumatic disorders that have serious consequences for their future life, health, schooling and socialization, and bring the risk of perpetuation of violence. It is as necessary to sensitize and train all the professionals who care for the traumatized children, in the medical, social, associative and judicial sectors about the psychotraumatic consequences of violence. Violence prevention concerns first and foremost the protection and care for the victims. In doing so, the child victims will no longer be condemned to silence, nor abandoned without protection and care, and will be able to come out of this hell where the traumatic memory of the sexual violence through which they went condemns them to live.

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Further reading :

The website of Mémoire traumatique et Victimologie : documents, ressources, IVSEA survey and training vidéos can be viewed and downloaded :

<http://www.memoiretraumatique.org>

<http://stopaudeni.com/>

<http://stopauxviolences.blogspot.fr/>

Dr. Salmona's books:

Le livre noir des violences sexuelles, 2nd Edition, Dunod, 2018

Violences sexuelles. Les 40 questions-réponses incontournables, Dunod, 2015

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Grossesse et violences conjugales : impact sur l'enfant, in *Enfants exposés à la violence conjugale*, revue L'observatoire, 59, 2008

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Salmona M. Le viol, crime absolu, dans le dossier *Le traumatisme du viol*, revue Santé Mentale, 176, mars 2013, pages 20-28. téléchargeable sur le site : http://www.memoiretraumatique.org/assets/files/doc_violences_sex/Le-viol-crime-absolu-Sant-

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et avec le Dr Patrice Louville : [Clinique du psychotraumatisme](#) dans le dossier *Le traumatisme du viol*, revue Santé Mentale, 176, mars 2013

Salmona M. La prise en charge médicale des enfants victimes in *Le parcours judiciaire de l'enfant victime* sous la direction de Attias D. et de K l., Eres, 201

Salmona M. La reconnaissance de l'impact psychotraumatique sur les enfants victimes de violences sexuelles, 2015, article publié sur les blogs médiapart et stop aux violences familiales, conjugales et sexuelles et téléchargeable sur le site : <http://www.memoiretraumatique.org/assets/files/Articles-Dr-MSalmona/201508-reconnaissance-des-consequences-psychotraumatiques-sur-les-enfants-victimes.pdf>

Salmona M. Le respect des droits des enfants à être protégés de toute forme de violence, et à recevoir tous les soins nécessaire quand ils en sont victimes devrait être un impératif absolu pour les pouvoirs publics in *Les enfants peuvent bien attendre : 25 regards d'experts* publié par l'UNICEF France, 2015, livre téléchargeable : https://unicef.hosting.augure.com/Augure_UNICEF/r/ContenuEnLigne/Download?id=24FFB60A-39E0-4459-8A6B-85B42A001312&filename=Les%20Enfants%20peuvent%20bien%20attendre.pdf

Salmona M. «En quoi connaître l'impact psychotraumatique des viols et des violences sexuelles est-il nécessaire pour mieux lutter contre le déni, la loi du silence et la culture du viol, pour mieux protéger les victimes et pour que leurs droits soient mieux respectés ?» 2016 téléchargeable sur le site <http://www.memoiretraumatique.org/assets/files/2016-Necessaire-connaissance-de-limpact-psychotraumatique-chez-les-victimes-de-viols.pdf>

Salmona M. Impact des psychotraumatismes, sur la santé et la scolarité in Dossier : Les blessures de la vie La revue de santé scolaire & universitaire Mai-Juin 2016, n° 39

Youth information booklets

Information sur les violences et leurs conséquences sur la santé, à destination des jeunes éditées en 2013 avec l'association Sortir du Silence, texte de la Dre Muriel Salmona, distribuées gratuitement par l'association, à télécharger sur le site [memoiretraumatique.org](http://www.memoiretraumatique.org/assets/files/Documents-pdf/brochure-jeunes-web.pdf) : <http://www.memoiretraumatique.org/assets/files/Documents-pdf/brochure-jeunes-web.pdf>

Information médicale sur les violences, à destination des adolescents réalisées en partenariat avec l'association Le Monde à Travers un Regard, texte de la Dre Muriel Salmona adaptation de Sokhna Fall, distribuées gratuitement par l'association, à télécharger sur le site [memoiretraumatique.org](http://www.memoiretraumatique.org/assets/files/Documents-pdf/plaquette-d-informations-sur-les-violences-mineurs-web.pdf) : <http://www.memoiretraumatique.org/assets/files/Documents-pdf/plaquette-d-informations-sur-les-violences-mineurs-web.pdf>

Recent victimation surveys in France and worldwide in the general population générale and among sexual violence victims

Enquête CSF Contexte de la sexualité en France de 2006, Bajos N., Bozon M. et l'équipe

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Les lettres numéro 4 et numéro 8 de l'Observatoire National des violences faites aux femmes de la MIPROF qui recense toutes les études et rapports sur les violences faites aux femmes ainsi que les données issues de l'activité des associations spécialisées, téléchargeable sur le site <http://stop-violences-femmes.gouv.fr>

Enquête IVSEA *Impact des violences sexuelles de l'enfance à l'âge adulte*, 2015, conduite auprès de plus de 1200 victimes de violences sexuelles par Association Mémoire Traumatique et Victimologie avec le soutien de l'UNICEF France: SALMONA Laure auteure, SALMONA Muriel coordinatrice, Rapport et synthèse téléchargeables sur les sites : <http://stopaudeni.com> et <http://www.memoiretraumatique.org>

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