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Preventive Treatment on Sexual Abuse Survivor with Mental Retardation

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ABSTRACT

The existence of limitations for children with mental retardation causes an inability to protect themselves so that they often become victims of sexual harassment. Preventive efforts are something that needs to be improved for prevention, considering the worse risks to children. The importance of an effort to prevent sexual abuse of children with mental retardation in connection with the lack of knowledge about sexual abuse and the inability of children to face the dangers that threaten themselves. From the results of research conducted in the United States in 1994, nearly 90% of children with mental retardation disorders had experienced sexual abuse, as many as 49% had experienced sexual abuse more than ten times. The high incidence of sexual abuse experienced by children with mental retardation is due to various factors, namely the condition of children's limitations, lack of supervision and protection of children by parents and the environment. Efforts that can be made are increasing knowledge about sexual abuse and self-protection skills through the Behavioral Skills Training Group Program, where children are trained to recognize threatening objects and situations (sexual abuse). Increasing knowledge about sexual abuse and providing training (self-protection skills) is a significant primary preventive measure to reduce the risk of sexual abuse in children with mental retardation.

1. Introduction

Children with mental retardation have a higher risk of facing sexual abuse than children without mental retardation. The increased risk is related to deficits in judgment and social skills. Some additional factors are deficits in communication, inability to seek help or report what happened. Besides that, there is an attitude from the family to isolate children which is a tradition with the assumption that children with mental disabilities do not need sex. so it is unthinkable to provide education about sex.

Lack of education about what is appropriate sexual behaviour causes children to become often dependent on these behaviours. In this case, the child usually becomes obedient to the offender and further increases the recurrence of sexual abuse. Besides the lack of sexual education for children with mental disabilities, children also do not know that sexual harassment is unusual or illegal activity.

Mild and moderate mentally disabled children can be given education about what sexual behaviour is and what sexual abuse is. Even with the limited level of intelligence, children with mild and moderate mental retardation can be trained in behavioural skills on how to avoid sexual harassment.[3]

The definition of mental retardation based on ICD-10 is a state of mental development that is stopped or incomplete, characterized by impairment of skills during development that affects all levels of intelligence, namely cognitive, language, motor and social abilities. Based on DSM IV mental retardation is defined as a disorder characterized by below-average intellectual function (IQ less than 70) starting before 18 years of age accompanied by a deficit in the adaptive

process (adaptive function is the environment can accept the individual's ability to face the need for independence virtually.

Sexual abuse is sexual harassment that includes various activities that are forced on someone. Sexual harassment consists of inappropriate and non-consensual sexual acts, such as exposure to sexual materials such as (such as pornography), use of inappropriate sexual comments or language, disrespect for the privacy (physical boundaries) of a person, fondling, exhibitionism, oral sex, and sexual relations with force (rape).[1,3]

According to research, most children with mental retardation experience some form of sexual abuse. In the general population, the percentage of sexual harassment ranges from 20% to women and 5 to 10% to men annually in the United States. In people with mental disabilities have the highest risk. More than 90% of people with mental disabilities were sexually abused. Forty-nine per cent will experience ten or more times. In another study found in girls 39 to 68 per cent, and in boys 16-30 per cent experienced sexuality before the age of 18 years. The incidence of child sexual abuse with mental disabilities is 15.000 to 19.000 per year in the United States.[1]

2. Case presentation

A 15-year-old girl patient with mild mental retardation and speech impaired comes to the RSCM Integrated Polyclinic with a request for visum et repertum by his family. A perpetrator is a man who is approximately 50 years old. The perpetrator has known the child since the child was still early childhood. The family knows the perpetrator well enough because the perpetrator often brings his child to shop and often gives the child money or food**.**

The family does not feel worried about the perpetrator because they already know and trust the perpetrator. Until one day, another neighbour reported the presence of unfavourable signs of the relationship between the child and the perpetrator. Neighbours often find the perpetrator taking the child to an empty house because of seeing the garden behind the open house. But the family at that time still didn't believe it. Until the time the child did not menstruate for the first time, the parents were still unsure about the child's condition. The family did not know precisely when the incidence of sexual abuse occurred, it was known that the child had missed menstruation for two periods, and the stomach looked enlarged. The child does not know well about what is going on. The patient still behaves jumping up and down, climbing trees, lying on his stomach. The child'slack of knowledge of the condition currently being experienced poses an adverse risk to the child and the unborn child.

The skills training in protecting oneself from sexual harassment provided is skills training for how children can differentiate and respond to or respond to situations of sexual harassment. In the curriculum for teaching self-protection skills to children with mental retardation, several formats are arranged in the form; Children are trained in several training sessions; using instructions; The expected response or feedback training model, reward or reward after performing an expected behaviour (reward).

The objectives of this protective behavior skills training cover three areas, namely for children to be able to verbally reject, leave situations of sexual harassment, report situations experienced to others.6 The results of the training show an increase in knowledge about sexual harassment and an increase in self-protection skills. They also show a reduced fear of objects, people and situations after attending the training program.[7]

3. Discussion

Most of the time, sexual abuse of children with mental retardation is carried out by known people, such as family members, relatives, nursing staff, personal caregivers. Research shows that 99-97% of perpetrators are people the victim knows and trusts. Thirty-two per cent of the perpetrators' cases were family members and relatives. 44% of the perpetrators had a special relationship with the victim, such as

home nursing staff, transportation providers, and private nursing staff.

Mentally disabled children have limited sexual knowledge and have little information about what sexual abuse is. So that the behaviour of protecting oneself from harassment is also inadequate, besides, they are unfamiliar and vague in reporting incidents of sexual harassment. As a preventive effort in abusing children with mental retardation, several interventions can be made, namely providing sexual education and providing information on what is meant by sexual abuse. In addition to increasing children's knowledge about sexuality, and understanding sexual harassment, training in behavioural skills to protect themselves from situations of sexual harassment is also conducted.

Children with mental retardation have thoughts, attitudes and feelings, desires and fantasies about sexuality. It is imperative to provide sexual education, given the high rate of sexual abuse in children with mental retardation. Most children with mental retardation begin puberty at the same age as non-retarded children and undergo the same physical and hormonal changes so that more education is needed to understand and manage these changes. Children with mental disabilities must explain the concept of sexual behaviour conforms to general norms and private sexual ideas.5

Sexual education in mentally disabled children can develop positive attitudes towards sexuality and help avoid sexual harassment, the transmission of infectious diseases, and unplanned pregnancies.5 Sex education can be provided by parents and possibly by professional personnel. But often sexual education is not given to children with mental disabilities for several reasons: there is a misconception about the view that children with mental disabilities do not need sexual education because the child will forever be a child; fear that if children are given knowledge about sex, they will be more likely to experiment sexually; the idea that a child who does not know about sex will have no desire to express their sexuality; it is difficult for parents to discuss sex with their children.

Parents may have tried to talk to their child about sex, but couldn't reveal the information in a way the child could understand. Failing to try can cause parents to give up. Children with mental retardation are often not aware that sexual harassment is related to violence and harm; this is because there is still a lack of education about sexuality.

Providing an introduction to sexual harassment behaviour, a training method with role-playing is used. Children are taught to recognize sexual prompting behaviours. In the opening of child sexual abuse behaviour, several kinds of touches are not appropriate for other people.

Several studies on the effectiveness of behavioural skills training programs in the primary prevention of sexual harassment have been conducted in China. The results showed that the modified behavioural skills training program was effective. Assessment of the effectiveness of this has been carried out on 72 children with mental retardation in China with a mild degree of mental retardation.

4. Conclusion

High rates of sexual abuse in children with mental retardation are associated with risk factors related to sexual harassment, including deficits in communication skills, impaired judgment, family isolation and living arrangements that increase vulnerabilit y. Lack of knowledge of children with mental retardation about sex and sexual abuse is a predictor of children's ability in self-protection behaviour skills. Preventive measures (primary) with the addition of sexual knowledge and training programs for self-protection skills against sexual harassment increase children's knowledge about sexual harassment behaviour and improve skills in protecting themselves.

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