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TREATMENT OF TRAUMA ASSOCIATED WITH CHILDHOOD SEXUAL ASSAULT

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The client was a 38-year-old male who attended a centre against sexual assault for counselling support related to childhood sexual assault. He presented with symptoms which supported a diagnosis of Post-Traumatic Stress Disorder. The basis for the therapeutic collaboration with the client was an early explanation of his presenting symptoms and discussion of treatment options. The client was seen for a total of 13 counselling sessions.

A combination of hypnosis, brief therapy, and cognitive-behavioural techniques was utilised in therapy. Hypnosis was used to help the client deal with nightmares, intrusive thoughts, and flashbacks relating to his childhood abuse. It was also effective in the client's management of his chronic pain and persistent sleeping disturbance. Brief-therapy techniques were utilised to facilitate client self-empowerment and ego-strengthening while cognitive-behavioural strategies were utilised for cognitive restructuring and formed the basis for an educative model that enabled the client to understand that his reactions were normal, given the trauma he had faced as a child and adolescent.

While the author was employed at a sexual assault centre located at a major hospital, a call was received in April 1994 by a man who reported that his son had been sexually assaulted by his stepfather. The caller described a need to talk about his son's abuse. In the course of the conversation, it became apparent that the caller himself had also been sexually assaulted and wanted to self-refer for counselling. The client stated his partner had also been sexually assaulted as a child and this, together with his concern about his son's abuse, appeared to provide the impetus for the client's self-referral. The client, who will be identified as Mr Blair, was seen for a total of 13 counselling sessions on a weekly basis over a period of four months.

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PRESENTING PROBLEM AND DIAGNOSIS

On initial assessment, the client described the following concerns:

1. nightmares which had persisted since childhood, occurring three or four times per week;
2. sleeping difficulties (he described obtaining only two or three hours undisturbed sleep per night);
3. regular and vivid images or flashbacks during the wakened state;
4. recurrent thoughts associated with childhood trauma;
5. avoidance of thoughts or feelings associated with the trauma (heavy dependence on alcohol as a way of coping with memories of abuse);
6. amnesia associated with the trauma — he had no memory of one year of childhood around age nine;
7. intense physiological reaction associated with trauma (rapid breathing, shaking, increased heart rate);
8. intimacy problems (emotional and sexual) with current partner and a number of prior unsuccessful relationships;
9. pain management problems, associated with a major injury to the left arm, which had contributed to a dependence on pain-killers and alcohol and finally resulted in a number of suicide attempts;
10. anger management issues associated with outbursts of aggression (for instance, the client spent time in prison for the assault of a man charged with the rape of a close relative, and also set fire to a home);
11. four suicide attempts, two as recent as 1993;
12. guilt and self-blame associated with his sexual assault.

Although symptoms of depression were noted, such as sleeplessness and self-blame, Mr Blair did not present as clinically depressed at the time. His symptoms were consistent with a diagnosis of Post-Traumatic Stress Disorder (PTSD; American Psychiatric Association, 1987).

PERSONAL HISTORY

Mr Blair was in a de facto relationship and had four sons from two previous relationships. He had no children to his current partner. He had contact with his sons, who all chose to live with their respective mothers.

Mr Blair was forced to retire from his work as a labourer when he injured his shoulder and neck in 1992. His current goal was to purchase a small business and work with his partner towards making the enterprise a success. Despite this optimism, Mr Blair described much of his life as being overshadowed by "demons" from the past (a reference to memories of abuse) from which he was anxious to free himself.

As a child, Mr Blair lived in isolated circumstances in a small country town. His first memory of being sexually assaulted was at nine years of age, shortly after his father left home. Mr Blair's mother and uncle began sexually assaulting

him and stopped only when he managed to flee from home at the age of 13.

Mr Blair said his father's departure resulted from his mother's sexual infidelities. He maintained contact with his father until the latter's death four years ago. Mr Blair did not disclose to his father his childhood sexual assault. In counselling, Mr Blair spoke fondly of his absent father, who he felt had been destroyed by his mother. Mr Blair avoids all contact with his mother, who occasionally calls him. His hatred and fear of her was deeply entrenched and he talks fondly of the day of her death (she is terminally ill).

Both sisters were living at home when the client was assaulted, although Mr Blair had no recollection of them witnessing any abuse. The eldest sister was removed by police from the home after she was forced into prostitution by her mother at the age of 12. The client believed that his youngest sister had also been sexually assaulted by their uncle.

The assaults were as frequent as once every evening during the school holidays and once or twice per week at other times. The assaults would sometimes last a number of hours involving anal penetration, digital penetration, enforced oral sex, and witnessing adult-to-adult rape. Throughout his ordeal he was told to remain silent and "not to be a little girl" and cry. The consequences of crying or screaming often meant enduring a more prolonged and brutal abuse.

Mr Blair left home at 13 years of age, the night after what he recalls as the most violent sexual assault by his mother and uncle. He sought refuge with neighbours, who cared for him over a period of four months. He suspected that they were aware of the abuse. Mr Blair remained in the care of the family until police forcibly returned him home. He fled from home the day he was returned and remained with his neighbours.

Given his home situation, the client was unable to receive a stable education. At school he suffered from poor concentration and required extra tuition in order to learn to read and write. Mr Blair believed he had missed an entire year of school (grade four) and expressed concern about the lack of memories for that year, which he feared had been particularly traumatic.

Mr Blair began abusing alcohol (up to one bottle of spirits every second day) at age 13, shortly after he left home. While working as a truck driver, he used a combination of amphetamines and marijuana from 16 to 18 years. At 17 years of age he attempted suicide through a drug and alcohol overdose.

Mr Blair's heavy drinking, combined with his frustrations and anger, contributed to his frequent violent outbursts. At the time of counselling he was on probation on a charge of assault. He had spent three months in prison for assaulting a man who raped his stepdaughter.

Shortly after Mr Blair's injury in 1992 he met his current partner. He described the relationship with her as supportive but at times difficult. The relationship was complicated by the fact that both parties had been sexually assaulted. Mr Blair was unable to enjoy sexual intimacy with his partner although he described a deep mutual affection existing between the two of them.

Mr Blair's partner was supportive of him during his attendance at counselling.

MEDICAL AND PSYCHIATRIC HISTORY

Mr Blair indicated that, prior to his work injury in 1992, he had had no major medical problems. At the time of assessment he relied on a combination of sleeping tablets, pain-killers, alcohol, and caffeine to manage pain associated with his injury. He had a history of chronic pain dating back to September 1992, when he sustained a neck and shoulder injury while working at a mobile crushing plant and had been recently diagnosed as having multiple cervical disc damage. Mr Blair has remained off work since 1992 and was financially dependent on Workcover benefits.

In 1993 Mr Blair underwent surgery, which involved the removal of a single rib and the "stapling" of damaged muscles in the left arm. Unfortunately the operation provided no pain relief. Frustrated with the failure of surgery to relieve his pain, Mr Blair took an overdose of medication on New Year's Eve and then drove his vehicle into a tree. Following this suicide attempt, he was referred by his general practitioner to a psychologist who assisted him with pain and anger management strategies.

Mr Blair was unaware of any psychiatric history in the family. He informed me that his father was a heavy drinker and that his youngest sister was both erratic and unstable. Mr Blair currently has a restraining order against his youngest sister, whom he described as threatening and violent.

Mr Blair had a history of suicide attempts prior to 1993. In 1982, following the loss of a child custody case in the Family Court, he overdosed and was admitted to Royal Park Psychiatric Hospital. An earlier suicide attempt occurred when the client was 17 years of age. At the time he was abusing amphetamines and marijuana and attempted to take his life using a combination of drugs and alcohol following a bout of depression. He recovered independently from this overdose. Mr Blair presented as a remarkably determined man who was highly motivated to make changes in his life for himself and his partner.

INTRODUCTION TO TREATMENT INTERVENTION

It was not possible to address all of the client's presenting problems, given the fact that the policy of the sexual assault centre was to provide only short-term counselling support to survivors of sexual assault. For this reason it was agreed that counselling support would focus on relieving some of the PTSD symptoms, which included nightmares, flashbacks, and intrusive thoughts associated with the client's childhood trauma. The therapeutic goals also included building the client's self-esteem and addressing feelings of guilt associated with abuse. However, later in the counselling process the client also requested assistance with pain management. In order to achieve these goals a combination of therapeutic approaches was used. These included hypnosis, cognitive-

behavioural techniques and brief therapy.

Hypnotic procedures were used initially as an adjunct to the cognitive-behavioural technique of systematic desensitisation, to aid symptom reduction (i.e., flashbacks, nightmares and thoughts related to his childhood sexual assault, and anxiety associated with memories of assault). Hypnosis was then used to calm the client following his description of traumatic events associated with his childhood sexual assault.

It was later decided that the client would visualise a particular traumatic image on a television screen and then switch channels to his "special place," rather than verbally describe the trauma, and then be hypnotised. This technique, once mastered, would enable the client to shift his focus away from any traumatic images, thoughts, or flashbacks if they occurred in the future. The technique described is a modified version of the "imaginary screen" described by Evans (1994).

Hypnosis was also used to assist the client manage chronic pain associated with his injury (Burrows & Dennerstein, 1988).

The Spiegel eye-roll hypnotic susceptibility measure indicated that the client was a high-trance subject. The Stanford Hypnotic Scale was not used because of concern that the age-regression component of this assessment could induce an abreaction in the client, who had faced severe trauma throughout much of his childhood.

SESSION 1

On initial assessment Mr Blair presented as tense and controlled as he fought to contain himself emotionally during the session. He later explained that he relied on tranquillisers in order to keep our first few appointments, which he found particularly difficult as this was the first time he had sought any professional counselling for his sexual assault.

In the first session, personal history details were recorded and information about his medical condition was obtained. An assessment was made of the client which supported a diagnosis of PTSD. I noted the client relied heavily on alcohol as a means of coping with current problems and memories relating to childhood abuse. Brief-therapy techniques were used to focus on the client's strengths and coping strategies as a means of building self-esteem.

Mr Blair indicated he had used relaxation in the past and that he was able to visualise a "special place" in the bush where he could relax. I suggested he could use this technique to assist with anger management problems.

SESSION 2

In this session I discussed with the client the nature and causes of PTSD. It was emphasised to the client that his responses were normal given the trauma he had endured. However, it was explained that more functional coping strategies

would be made available to him through counselling. The treatment strategy of systematic desensitisation was explained, using a number of examples to illustrate how it worked.

The notion of using hypnosis to assist the client in his recovery was introduced. I explained to Mr Blair that hypnosis could help him reduce the physical and psychological impact of memories associated with his childhood sexual assault.

A paradoxical challenge was issued to the client: I informed him of the low compliance rate of many PTSD sufferers and explained that only particularly determined individuals remained in counselling and confronted their problems. The client insisted that he was one who would meet this personal challenge. A hierarchy of fears associated with the client's past traumas was then formulated. The client's strong motivation and rapport with the therapist were important factors in contributing to the successful application of hypnosis (Burrows & Dennerstein, 1988).

In the remainder of the session brief therapy was used to reframe the client's experience of the abuse to provide him with the opportunity to acknowledge the resources and survival skills which enabled him to psychologically cope with the repeated sexual assault and finally leave the family home.

SESSION 3

Systematic desensitisation and hypnosis were utilised in this session. It was agreed that Mr Blair would talk about his first memory of sexual assault, which he felt was the easiest memory to confront. As he began to verbally recall (in the awakened state) the events associated with this memory, he became tense and visibly distressed. He was reminded that if he needed to stop at any stage he could do so.

Following this description of the trauma, hypnosis was used to calm the client and ego-strengthening suggestions were made. Mr Blair was asked to focus on his breathing and imagine a wave of relaxation flowing through his body, starting from his head and progressing down to his feet. As the wave progressed he was asked to imagine any tension or stress flow away from his body. He was invited to further deepen his trance by focusing an a numerical count from 1 to 5, after which he could experience an even greater state of relaxation. Following this Mr Blair was asked to imagine himself in his "special place" by a river in the bush. Ego-strengthening suggestions were made to increase the client's self-esteem. He was asked to take whatever he needed from his "special place" and I suggested his unconscious mind might wish to take comfort, security, or confidence to assist his conscious mind deal with day-to-day living.

Following hypnosis, Mr Blair reported he was able to relax and feel in control after remembering the trauma of his first abuse. He explained that, in the hypnotic state, he had imagined himself floating in the water and seeing red and

orange lights, which he described as reassuring and comfortable. The metaphor of floating is helpful in assisting PTSD sufferers in dissociating the mental experience of the trauma from the physical experience (Evans, 1994). In a later session the client explained the orange lights were those of trucks, which were like coats of armour that would protect him.

SESSION 4

At the fourth session, Mr Blair reported that he felt calmer since the last session and had benefited from talking about issues surrounding his past sexual assault. He explained he had successfully managed to deal with his youngest sister, who arrived at his home violently abusing him and making a variety of accusations against him. In the past he would cope with this type of stress through binge drinking. Now he had relied on relaxation strategies and some medication to assist him in dealing effectively with the situation. In the remainder of the session the client agreed to work on reducing his dependence on pain-killers and we talked about utilising alternative pain management strategies. Mr Blair agreed to work on decreasing his caffeine intake from eight cups per day to one or two per day, as a first step towards improving his sleep.

SESSION 5

In this session, Mr Blair informed me he was experiencing violent nightmares about killing his mother. He attributed this to his willingness now to talk about the assault and his anger towards his mother. To help him displace this anger, I suggested he write a letter to his mother stating how he felt. I explained the letter would not be sent, avoiding his fear of giving power to his mother through a written outpouring of emotions. The client felt he was not ready to write such a letter at this stage. In retrospect, the option of providing the client with the opportunity to confront his mother while in the trance state, as an adult, could have been utilised. He continued to refer to the possibility of his mother's death as his only means of gaining "peace of mind."

Mr Blair agreed to continue with the desensitisation process and did so by describing his last memory of sexual assault. During this process he became very distressed, clenching his fists and changing his facial expression. Hypnosis was used to relax and calm him. The induction and deepening techniques used in session 3 were again utilised. However, the suggestion was made to the client to imagine a balloon in which he could place any unwanted concerns. The client appeared to awaken from the trance state and described feeling nauseous (he was visibly ill and disoriented) as he was struggling to place a particularly difficult memory into the balloon. I reassured him he was safe and recommenced hypnosis using a brief induction, deepening, and then asked the client to return to his "special place" taking whatever he needed from this place that would be comforting to him. Mr Blair was visibly calm and relaxed when

he came out of trance. His ability to control the emotional and physical impact of the memories by focusing on his "special place" was reinforced.

Following the client's apparent abreaction to the suggestion of letting go his concerns, it was important to ensure that he left the session in a calm state, hence the decision to reinduce trance. This was to avoid a paired association between hypnosis and anxiety. In retrospect, providing the client with the opportunity to let go of concerns associated with his traumatic experience may have been premature.

It was of concern that, through reliving the trauma of his past abuse, Mr Blair appeared to be reliving the experience. This re-experiencing of the trauma had produced an intense physical abreaction in the client. An attempt was made to reduce the intensity of any future abreactions, should they occur again in the course of treatment.

SESSION 6

Instead of using hypnosis to calm the client following his verbal description of a past trauma, I suggested the client visualise intrusive thoughts or images on a television screen and control these by switching channels to his "special place." I explained this technique would initially be practised under guided hypnosis, but with adequate rehearsal he could visualise any disturbing thoughts that came to him and "switch channels" independently through mastery of self- hypnosis.

Before this technique could be used, Mr Blair complained of pain associated with his left shoulder injury. He was enthusiastic about using hypnosis to assist in pain management. When asked to describe the pain on a scale of 1 to 10, he complained it ranged mostly between 9 and 10. In this session he indicated his pain was at 8.

When asked to describe what was helpful in reducing pain in the past, he recalled he had enjoyed the numbing sensation induced by anaesthetic following surgery. Utilising this pleasurable sensation as the basis for hypnoanesthesia, I asked him to use an image of heat or ice to recreate the relief he had previously enjoyed. He expressed a preference for ice.

The same induction and deepening technique described in the earlier sessions was used. The client was asked to imagine himself in his "special place," lying on the ground in a tub of iced water. I suggested that, when he placed his arm and shoulder into the water, he would not experience any pain or discomfort but rather would enjoy a gradual numbing sensation. Ideomotor signalling was used to communicate with the client, to determine whether he was able to visualise the iced water and was ready to place his arm into the tub and then remove it when numb.

I concluded with a post-hypnotic suggestion that, by closing his eyes and imagining himself in his "special place," he could reproduce the feeling of numbness in his arm whenever required. I also suggested this sensation of comfort and relief would increase each time he used this technique.

Mr Blair indicated his surprise at how well he felt following hypnosis. His pain rating dropped from 8 to 4 and, although it was still present, it was not distracting or irritating. He described feeling comfortable and he experienced diminished swelling and increased flexibility in his left arm and shoulder. He reported that throughout the process his right arm had felt hot.

At the end of the session Mr Blair reported he had refrained from alcohol consumption in the past week. This had coincided with a breakthrough in the client's progress, in that he no longer blamed himself for his childhood sexual assault and, for the first time, had said "it wasn't my fault."

SESSION 7

In this session the client reported no vivid nightmares since the last session. This had coincided with the use of relaxation strategies to assist with sleep.

The alternative hypnotic technique discussed in session 6 was utilised. The client was asked to imagine himself relaxed in bed watching a blank television screen. He was then asked to turn on the television and visualise an image from the past. It should be noted that prior to the induction the client agreed to visualise an image that would evoke minimal emotional stress. The client agreed to avoid images of severe abuse. Ideomotor signalling was used to determine whether the client could visualise the blank screen and trauma image.

When asked to visualise the trauma image (in as detached a way as possible) the client became visibly distressed and his breathing increased. He was asked to indicate when he was ready to change channels to his "special place." The client's face and body became visibly relaxed as he became absorbed in his "special place." A post-hypnotic suggestion was made that any intrusive thoughts or images associated with his past trauma could be seen in a detached way on a television screen which he could control by changing channels to his "special place" whenever he so desired.

In feedback after the hypnotic session Mr Blair reported that, when asked to change channels, he had hesitated for a moment. However, he had succeeded in switching to his "special place." He described the transition from the trauma memory to his "special place" as being like walking from a freezer into a safe, warm place where he felt comfortable and at ease.

At the end of the session Mr Blair informed me he had successfully used the hypnotic technique taught to him to manage pain in his arm and shoulder. He explained it took some time before he could immerse himself in his "special place" and picture his arm in iced water. However, he had succeeded in using this method up to three days in a week and had reduced his pain from around 8 to 3 on a scale of 10.

SESSIONS 8 – 13

These sessions focused on preparing of the client for surgery. He was suffering from significant damage to the discs in his neck which could not be repaired.

In later sessions Mr Blair reported that he had suffered from flashbacks to his abuse, but had been able to control his emotional reactions using retreat to his "special place." He had begun sexual relations with his partner and felt his communication had improved and speculated this may have contributed to the absence of any recent violent or aggressive outbursts with his partner or other people. By the end of therapy, Mr Blair felt able to write the letter to his mother. However, during the thirteenth session he revealed he and his partner had decided to separate, after fighting over maintenance for his partner's son. He had begun drinking again and felt his life was falling apart. Mr Blair then abruptly terminated the session and left the office.

FOLLOW-UP DISCUSSION

Some months after his last session, Mr Blair contacted me by telephone to request a further appointment. A week later he telephoned and explained he had decided to continue to manage his problems independently and would contact me if further assistance was required.

CONCLUSION

The treatment of long-term PTSD sufferers is both challenging and draining, particularly when there are multiple problems that are often firmly entrenched. In this case, hypnosis was useful in providing the client with the opportunity to find alternative means of dealing with his PTSD symptoms and chronic pain. Throughout the process I was impressed with his resilience and ability to use self-hypnosis with very limited rehearsal. The brief-therapy techniques utilised as early as session 2 were important in assisting the client to resist self-blame and guilt, and cognitive-behavioural strategies were helpful in thought restructuring in relation to pain and anger management issues.

Despite the overwhelming problems faced by this client, it was apparent he had made significant gains which endured over a period of some months. I felt he would probably continue to experience major difficulties in his life. However, counselling provided him with alternative techniques to the self-destructive coping strategies he relied on in the past. The responsibility for utilising these self-help techniques must rest with the client.

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