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Treating the Psychological Sequelae of Proactive Drug-Facilitated Sexual Assault: Knowledge Building Through Systematic Case Based Research

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Background: Drug-facilitated sexual assault (DFSA) has emerged as a distinct category of sexual victimization and precipitates posttraumatic stress disorder (PTSD). Few studies have examined the distinct psychological aspects of PTSD caused by DFSA. Gauntlett-Gilbert, Keegan and Petrak (2004) represent a notable exception and draw on cases, from their clinical experience, treated using Ehlers and Clarks' (2000) cognitive therapy (CT). **Aims:** This paper aims to further develop and refine clinical knowledge on CT for PTSD arising from DFSA and advance the findings of Gauntlett-Gilbert et al. (2004). **Method:** Systematic case based research was used to investigate the applicability of CT for PTSD related to DFSA. Three survivors were treated with CT within the South African context. **Results:** The case series corroborated existing findings but also documented the presence of somatic and visual intrusions among survivors with partial or complete amnesia for rape and illustrated the utility of imagery interventions in targeting intrusions. The study highlighted the role of physical paralysis in DFSA in compounding helplessness/powerlessness and the necessity of enhancing physical agency and building social support. **Conclusion:** Distinctive aspects of PTSD related to DFSA can be effectively treated by adapting CT to suit this population group.

Keywords: Cognitive therapy, PTSD, qualitative methods, psychotherapy process, intrusive thoughts, cognitive behavioural intervention, adults.

Introduction

Gauntlett-Gilbert, Keegan and Petrak (2004) reported that post-traumatic stress disorder (PTSD) consequent on drug-facilitated sexual assault (DFSA) can be effectively treated with Ehlers and Clark's cognitive therapy (CT) (Ehlers, Clark, Hackmann, McManus and Fennell, 2005), and summarized clinical features found to be salient for treatment planning. In "proactive" DFSA, perpetrators deliberately incapacitate victims by plying them with alcohol or covertly administering an incapacitating drug such as Flunitrazepam (Rohypnol) or Gamma-hydroxybutyrate (GHB) (Hall and Moore, 2008). In contrast, "opportunistic" DFSA is perpetrated on women who have voluntarily taken drugs or consumed an excessive amount of alcohol. In this report, three systematic case studies conducted in South Africa on the

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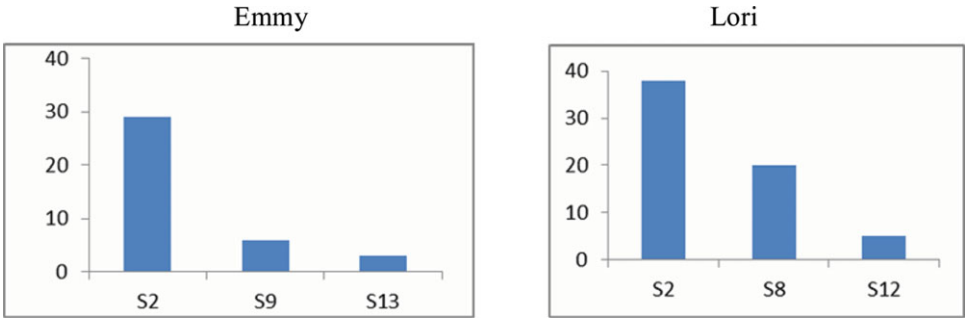

Figure 1. (Colour online) PDS scores

treatment of PTSD following proactive DFSA were used to refine and expand on Gauntlett-Gilbert et al.'s (2004) work. Two of the women were South African: Lori (21), a student, and Anna (43), a health professional. The third, Emmy (21), was an exchange student from North America. All had co-morbid major depressive disorder. In each case there was evidence that the perpetrator had used a drug to incapacitate them before raping them.

Method

For each case, an assessment summary, a case formulation, and a treatment narrative were written based on session records and transcripts of voice recordings of all sessions (see Dattilio, Edwards and Fishman, 2010). The Post-traumatic Diagnostic Scale (PDS) – Part 3 (Foa, Cashman, Jaycox and Perry, 1997) and the Beck Depression Inventory (BDI-II:Beck, Steer and Brown, 1996) were administered regularly. This material was then the focus of an interpretive thematic cross-case review of factors salient in the treatment of DFSA, identified a priori from Gauntlett-Gilbert et al.'s (2004) work and post hoc from the material of the current cases.

Results

In all cases, the PTSD and comorbid depression resolved. PDS scores for Emmy who had 13 sessions and Lori, who had 12, are shown in Figure 1. Anna's treatment, which also addressed characterological problems, lasted 44 sessions. Summaries of the assessments and case narratives as well as vignettes illustrating specific aspects of treatment are included in the extended version of this article. These show the importance of individual case formulation and identifying idiosyncratic personal meanings and illustrate work with somatic intrusions.

Themes for treatment implementation

The cross-case review identified seven themes salient for treatment implementation. Two of these were not regarded as specific to DFSA cases: (1) "Psychoeducation orients clients to work for change" and (2) "Building social support undercuts shame and increases motivation to change." Features of the remaining five are summarized below.

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(3) Survivors may not realise the rape was drug-facilitated. None of these clients were initially aware they were victims of DFSA. This aspect, not identified by Gauntlett-Gilbert et al. (2004), has specific implications for assessment and treatment. Since alcohol can produce symptoms similar to that of drugs used in DFSA, not only survivors but also clinicians may mistakenly attribute symptoms such as amnesia and other physical reactions to alcohol intoxication. It only became clear to Emmy (a year after her rape) and Lori (5 months after her rape), during the assessment, that they had been deliberately drugged and symptoms were not due to alcohol intoxication. Anna had been raped 25 years before this treatment. For 6 years she had felt confused as she had not consumed alcohol the night of the rape and had no knowledge of DFSA. She had subsequently researched her symptoms and realized her rape was drug facilitated. Psycho-education about the effects of DFSA drugs was very important for Lori and Anna. It led to Lori questioning the basis of her self-blame. Anna valued the validation of her conclusion that her rape had been a DFSA as it normalized her confusion. Initially the impact on Emmy, who had an extremely positive worldview, was different, as it shattered her belief in personal control:

> to consider that I was drugged as well . . . I don't know. . .. I guess it kinda helped the fact that I can blame myself . . . I had some control but then if I was drugged and raped then . . . I become a complete victim.

Emmy was guided to rebuild her assumptive world, by reviewing and clarifying the personal meanings ascribed to the trauma, in a way that accounted for her victimization.

(4) Promote safety especially when DFSA is perpetrated in the survivor's home. The familiar location in which DFSA is often perpetrated exacerbates clients' sense of vulnerability. Lori and Emmy were raped in their bedrooms and experienced intrusions and hyperarousal in this setting. As suggested by Gauntlett-Gilbert et al. (2004), therefore, promoting a sense of safety is an important focus of treatment. Lori rearranged her room to minimize any association with the rape and, during a home visit, no obvious triggers could be identified. Work on the trauma memory (restructuring within reliving) and restructuring her nightmares led to marked reduction in her reported hyperarousal but she still found it difficult to sleep at night. Lying in bed, her thoughts largely revolved around the possibility of an intruder entering her home and harming her. Emphasizing that she lived in a secure neighbourhood with three other female students and was rarely alone at night enabled her to challenge these thoughts, leading to some anxiety reduction. However, residual triggering from cues in her room was probably contributing to the symptom maintenance because, 3 weeks after treatment, she relocated to a different house and her residual symptoms completely resolved. Emmy feared she would not cope when she returned to North America and the trauma site. Imaginal rehearsal of returning to the trauma site helped her identify the emotions she might experience and how she could deal with them. Visualizing her father walking beside her, in the imaginal rehearsal, enhanced her sense of security.

(5) Enhance physical agency and empowerment. The helplessness typically experienced by rape victims was exacerbated for these women by drug induced paralysis. Imagery rescripting was valuable in reaffirming physical agency. Emmy visualized herself pushing the rapist away and returning to a place of safety. Lori said she wanted a physical means of reasserting her agency and found it helpful to re-engage with physical exercise. She was helped to feel more physically assertive through restructuring of recurrent nightmares in which she was physically paralysed. Anna's experience of herself as helpless and powerless was embedded in childhood

schemas that were addressed through imagery rescripting of certain childhood memories. Another avenue of empowerment is to support clients in taking legal action, although cases of DFSA are difficult to prosecute due to survivors' amnesia and time delays in reporting. Lori was assisted in investigating her legal options. She discovered that, in South Africa, irrespective of the time delay in reporting, a survivor could submit an affidavit to the police detailing the crime. This would serve as evidence if the perpetrator committed a similar offence. Doing this was experienced as empowering and helped her to achieve "closure". The therapist discussed with Emmy the legal options available in North America, which Emmy believed would ensure that she was able to make the perpetrator accountable for his crime. Legal action was not an option for Anna since the incident had taken place so long ago and the perpetrator was unknown to her.

(6) Address amnesia within the trauma memory. The present cases all featured the partial (Anna, Emmy) or complete (Lori) amnesia highly prevalent among survivors of DFSA (Gauntlett-Gilbert et al., 2004). Such amnesia does not protect against PTSD, which also regularly occurs in patients with post-traumatic amnesia following traumatic brain injury (TBI). Data-driven processing and the resultant fragmented recall often mean that clients with PTSD have difficulty recovering trauma memories, which leaves them confused about what actually happened (Ehlers et al., 2005). This can be addressed in treatment. However, amnesia due to drugs or TBI cannot be reversed. This becomes a problem where, as in the case of Lori, survivors believe they need to remember in order to recover from the trauma and start to ruminate in an attempt to retrieve the memories (Gauntlett-Gilbert et al., 2004). This was effectively addressed through psychoeducation and, once Lori no longer believed that remembering was a pre-requisite for recovery, she stopped ruminating.

(7) Address intrusions, especially somatic intrusions. Gauntlett-Gilbert et al. (2004) reported that in DFSA cases intrusions were either visual or "affect without recollection" described as "surges of emotion in response to a specific cue in the absence of a specific memory" (p. 218). However, their example, of a "survivor [who] experienced intrusions of the feeling of hair on her face, and overwhelming distress associated with a specific smell" includes a "somatic" intrusion (the feeling of hair) and an "olfactory" intrusion. We would therefore not consider this affect without recollection, but an intrusive memory without a visual component, involving recall in other sensory modalities. Somatic intrusions were particularly prominent in all three of our cases and were treated with restructuring within and outside reliving. Lori experienced a somatic intrusion of a feeling of a heavy weight on her accompanied by confusion: "I'm not entirely sure what is going on" . . . "I can't breathe. . . I just want it to stop" ". . . I don't know why I can't wake up". This memory was updated with corrective information and the intrusion did not recur. Emmy reported an intrusion that was entirely somatic: her body feeling "limp" associated with disgust/contamination related to the perpetrator compromising her virginity and experience of herself as pure. In the rescript, Emmy visualized herself being released from her paralysis, pushing the perpetrator away, chasing him out and then returning to a friend's room and being tightly held by her friend.

Discussion and conclusions

These cases studies corroborate and expand on the findings of Gauntlett-Gilbert et al. (2004). Since survivors may not realize their assault was drug facilitated, careful attention needs to be paid to the phenomenology of the client's experiences during assessment. Interventions

aimed at building social support, restoring a sense of agency and building a vision of a life beyond the trauma are part of the CT model for PTSD following any form of trauma, and were significant components of treatment in all the present cases. Some assumptions identified by Gauntlett-Gilbert et al. (2004) as salient for DFSA survivors were found in some of our cases: Lori was ruminating in an attempt to recover a fuller memory, and both Lori and Emmy blamed themselves for the rape because of their alcohol consumption. However, none of them had experienced negative social responses following disclosure. It was important to address amnesia in the trauma memory and to identify somatic intrusions, understand them, and rescript them. Upon examination, somatic intrusions could be understood as coherent memories that, despite the absence of full episodic recall, could be worked with in the same manner as those in other sensory modalities.

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