- Rape and sexual assault with drugs -
TPR treatment
Trauma Psychotherapy by Reassociation

The specifics of using Trauma Psychotherapy by Reassociation TPR (a strategic conversational hypnosis) for the desensitisation of trauma caused by rape committed with drugs, alcohol, rohypnol, opiates, benzodiazepines or GHB, the so-called "rape drug".

Observers inexperienced in trauma treatment might rightfully wonder how a person who has been the victim of sexual assault when in a state of total unconsciousness could have symptoms normally associated with cases of Post-Traumatic Stress Disorder (PTSD). However, regardless if the patient is totally unaware of having been the victim of this type of sexual assault or if they have only a few memories of before and after the assault, the presence of psychological trauma symptoms is striking.

Some victims only remember having a few drinks with friends and losing consciousness at some point in the evening. Others are more troubled at inexplicably waking up in a place they don't remember going to. For others, an injury or the presence of sperm may be the only things that provide them with the slightest inkling of what happened.

As in most cases of sexual assault, PTSD symptoms will only appear some time later. The symptoms include:
Fear, anxiety, phobias, depression, flashbacks to emotions, recurring dreams (without images), a feeling of being dirty and of personal degradation. Sometimes, the victim experiences "identification with the aggressor" which includes anger and feelings of rage against friends, parents, children (1), etc.
Self-mutilation and destruction of relationships and of social life is also frequent.
We know that rape victims feel guilty about what happened to them.
The guilt is always there, even for those who don't remember the sexual assault. It grafts itself onto whatever it can: living, feeling unwell, violence, etc.
For some people who have no memory of the rape(s) - sometimes gang rape - the symptomatic can also take a form which can be referred to as "borderline" or "psychotic" as a result of very powerful dissociative symptoms.

In all of these cases, Trauma Psychotherapy by Reassociation (TPR) a strategic conversational hypnosis is a preferred tool for therapists who have to care for the after-effects this type of sexual assault. (http://imheb.be/formations-accessibles-aux-therapeutes-chevronnes-comme-aux-debutants/)

We will not redefine strategic conversational hypnosis at this time, but simply note that this type of hypnosis is active in the sense that the patient and therapist are in conversation at all times. The patient is in a permanent state of altered consciousness. They experiment several hypnotic phenomena and learn (2) to manage their autonomic nervous system (3) (emotions and sensations) and to rebuild their sense of safety and comfort to be able to protect themselves against a recurrence of the double-edged elements (psychological and chemical) they have erased and which can be too violent, distressing, etc.
The purpose of all this is to enable the amnesia to lift as gently and as safely as possible.
We should underscore that natural, dissociative amnesia, coupled in this case with chemical amnesia, provides "hypnotic protection" against fear and the incomprehension of feelings of loss of self-control created by the involuntary taking of drugs.

The technique described in the three "cases" below has been used many times with the victims of rape and sexual assault under chemical influence. In the case of single assaults, two or three sessions were usually sufficient to deal with the essential symptoms.
Let's start with a brief description of the history and symptoms of "Anne", "Danielle" and "Martine".
Let's start with Anne, 26.
Anne had been suffering from intense nightmares without images and flashbacks for a year. She had extremely low self-esteem which led her to drop her studies. She had been living a sexual frenzy since the assault. She no longer felt able to love, just able "to have sex" to be able to dominate the exchanges. She wanted to die. She no longer had a social life and her educational and professional lives were suffering.
She only remembered the following about the assault:
She had a few drinks in a bar and felt quite ill. The young man with her told their other friends that he would drive her home. Anne remembers that she fell and banged her head on a concrete block next to the car. She hardly felt anything, but the next morning, she found that her sheets were stained with blood. She would need several stitches to close the wound. The young man who drove her home was still there when she woke up. When she went to the toilet, she noticed sperm running from her vagina.
See the link below:
http://imheb.be/temoignages-de-patients/

Danielle, 32.
She had been very violent for years. She came to see me because she was being violent with her child. She had always been very anxious and believed that she failed her studies (etc) because she was raped when she was 14. The only thing she remembered was that it was her birthday and that she was at the party which was at a friend’s house. She never understood why she woke up at home. Her friend told her that three boys who had been at the birthday party boasted of raping her.

Martine, 22.
She came to see me after two years of therapy with psychoanalysis. She said that it was two years of suffering. It was useless because she had made no progress...if anything, she felt even guiltier.
She mutilated her genitals the day after the sexual assault, which she had no recollection of. She dropped her boyfriend because she felt guilty and dirty. In the days that followed, she engineered a conflict with her best friend and stopped seeing her. She dropped her medical studies and classical choir. She had been singing since childhood and had become very proficient. In just a few days, her relationship with her family, and particularly, with her mother, became disastrous and violent. Martine convinced herself that she was worthless and guilty.
She remembered that she had been to a country dance where she met a nice young man. She had had a couple of glasses of white wine and took two drags on a joint in the car as they drove back to Brussels. She thought that it was all her fault, although she realised that the amount of wine and hashish she had shouldn't have put her in that state.
She agreed to sleep at the young man's house "as a friend" and only remembers passing out after she got there. She left the young man's apartment quickly the next morning. She felt ashamed and like she had done something awful.

I'll only talk about these three cases which i've taken from a list that has enabled me to develop a summary of the therapeutic structure similar for all of them.

Each situation was, of course, treated with strategic conversational hypnosis.
It seems increasingly obvious that an altered state of consciousness is indispensable to treat psychological trauma. As David Cheek and others who developed the theory have stated, an altered state of consciousness is the source of all PTSD and, logically, a later altered state of consciousness is necessary to locate and desensitise it.

The fear created by the appearance of unexplained internal sensations, loss of self-control and strong emotions caused by a chemical substance create the initial altered state of consciousness.

This is probably the first specificity of PTSD caused by rape with the use of drugs. The victim enters an altered state of consciousness because of the fear created by her changed perceptions. There is a feeling of being anaesthetised with heaviness, numbness, unresponsive arms and legs, the inability to speak or to react, vision problems, distorted auditory perception, etc. What is more, after the assault, a number of victims continue to live with dizziness and feel like they have "limp legs", etc.
One of the main concepts underpinning PTR (Trauma Psychotherapy by Reassocation) is that the hypnotic phenomena appearing spontaneously at the time of the traumatic incident are a dissociative protection mechanism*. In PTR, they are used for desensitisation and as a way for patients to tame the phenomena which later became part of their PTSF symptoms.

In PTR, once the altered state of consciousness has set in, we ask the patient to follow, develop, use, and transform all of the fears caused by the effects of chemical agents and, especially, to recognise and "play" (foil) with the sensations induced by the same drugs. The therapist’s encouragement and explanations are essential: it isn’t natural to relive such disagreeable feelings. Moreover, they can go nearly "unnoticed" given the "anaesthetised" condition of the victim. The therapist must insist that the patient "dare to feel the sensation of not feeling", the sensation of numbness, the sensation of having a heavy head, or of dizziness, etc.

They must explain that the more the patient focuses on these sensations, after intensifying them somewhat, the sooner they will disappear. The patient learns to control them. Seen from this angle, the patient can play with them. The patient is no longer overwhelmed by them and can imprint their will on them. The sensations will also be recognised as vestiges, recorded in memory, of the effects of the drug which, although the cause is unknown, stayed with the patient as symptoms. Other memories will start to reappear thanks to the focus on the drug experience. Were they forgotten because of the anaesthesia or because of a subsequent hypnotic protection reaction? The question hasn’t been answered. However, the rediscovery of certain information that follows, even when minimal, will lead to desensitisation of the trauma and to a cognitive change from the usual "it's my fault, I'm guilty" of trauma victims.

Work with Anne:
Likely a victim of GHB. When I asked her to focus on her feelings or emotions, she wasn't able to. A vague memory of pain on her forehead and cheek caused by a fall in a parking lot reappeared. However, when I asked her to focus on the effects of the drug, she gradually remembered the general feeling of numbness and, especially, the "lack of strength". It was then, and starting with that, that she remembered having made a superhuman effort to struggle free from her aggressor. She remembered being powerless to fight against him and unable to move. Her cognition changed virtually instantaneously. Following this proof of the contrary, she moved from "I'm guilty, it's my fault" to "I tried to fight with all my strength, but the drug stopped me!"

The treatment was already nearly complete given that the primary way to measure the success of trauma therapy is by the correction of erroneous cognition. The session had also consisted in removing all of the sensations left by the drug by having her feel them again and “covering” them with other, pleasant and regenerating sensations.

Work with Danielle:
Induction of conversational hypnosis and training with several hypnotic phenomena followed by a "dissociated" visit to the room and bed where the three young rapists held her down. She doesn't see them (which is normal for people who have been drugged since their eyes are close), but she hears them. They're laughing and seem to be having a lot of fun. She recognises their voices and can identify them without hesitation. When I ask, she plunges into the sensations generated by the drug, which may have been Rohypnol (?). She began to strengthen the sensations to feel them better then, thanks to the amplification, was able to decrease him. She too noticed that she was physically powerless to fight. But remembering the scene was enough to enable her to transform the cognition and realize that "it really did happen to me, I'm not crazy!" She also understood many things about her life and the many symptoms that resulted from the assault. She came out of the hypnosis with a feeling of forgiveness for herself, for her emotional excesses (victim "identified with the aggressor" syndrome) over the years. Most of Danielle’s symptoms went away almost immediately (in particular her fear and the violence against her son and other loved ones). She also recovered her self-esteem. Concrete accomplishments in her professional life, among others, later confirmed these drastic emotional changes.
Work with Martine:
Victim of Rohypnol (?) We should note that Martine had accepted to sleep at the young man’s house because he wasn’t going in her direction. She was to go home the following morning. He had seemed polite and respectful.
Under hypnosis, Martine was able to remember that she drank some orange juice the Y.M. gave her. They talked for a while. She didn’t feel well and went to the bathroom. When she got up and walked towards the door, she suddenly fell.
I continued with the conversational hypnosis and asked her to focus on the drug sensations. They came very quickly: numbness, noises in her ears, weak arms and legs, etc. After a few moments, she began to remember words and sentences...The Y.M. spoke to her softly, lovingly. He called her by another person’s name. There was a large picture of that person on the wall above the bed. She felt her anger rising with difficulty, but was happy to remember that she rebelled against that scene in which the Y.M. was making her play someone else’s role...She became even more aware of wanting to run away from the place in the morning. Once she remembered her desire to run away under hypnosis, she immediately began to wonder where the absurd idea that she was guilty had come from when, in fact, she was the victim! After the Trauma Psychotherapy by Reassociation (PTR) session, Martine quickly took control of her life again and went back to university. She recovered her self-esteem.

In summary
On one hand, focusing on the sensations induced by the drug leads to their elimination, and to finding the few helpful bits of information that remove the feeling of guilt.
On the other, it’s the use of "Dissociative Protections", the feelings of anaesthesia, paralysis and catalepsy caused by the fear of losing control (fear of death) after taking drugs that makes it possible to eliminate the PTSD symptoms.
In every case, PTR therapy relies heavily on the vestiges of drug-induced sensations and on the paradox of dissociative protection. They are helpful at the moment of the traumatic incident, but become inhibiting symptoms (or vehicles for symptoms). They are then used in a positive way as hypnotic skills of the patient... and no longer have any reason for being!

*(Dissociative Protection: a term coined to stress the initially protective nature of specific dissociative hypnotic phenomena developed by the person at the moment of the traumatic incident. These hypnotic phenomena later become symptoms or vehicles for symptoms.)


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