NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Previously copyrighted materials (journal articles, published tests, etc.) are not filmed.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

Les documents qui font déjà l'objet d'un droit d'auteur (articles de revue, tests publiés, etc.) ne sont pas microfilmés.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30.

THE UNIVERSITY OF ALBERTA

VISUAL-KINESTHETIC DISASSOCIATION IN TREATMENT OF VICTIMS OF RAPE

GORDON L. McLEOD

A Thesis Submitted to the Faculty of duate Studies and Research in Partial Fulfillment of the Requirements for the Degree of Master of Education

In Counselling Psychology

Department of Educational Psychology

Edmonton, Alberta

Fall 1987

ISBN 0-315-41093-0

THE UNIVERSITY OF ALBERTA

RELEASE FORM

Name of Author: GORDON L. McLEOD

Title of Thesis: VISUAL-KINESTHETIC DISASSOCIATION IN TREATMENT OF VICTIMS OF RAPE

Degree: MASTER OF EDUCATION

Year this Degree Granted: 1987

(Student's signature)

1983 Glenmore Avenue,
Sherwood Park, Alberta

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled

Visual-Kinesthetic Disassociation In Treatment of Victims of Rape

Submitted by Gordon L. McLeod

in partial fulfillment of the requirements for the degree of Master of Education in Counselling Psychology

Supervisor

Date: Fall 1987

June 1/87

ABSTRACT

A Visual-Kinesthetic Disassociation procedure of Neuro-Linguistic Programming (NLP) was employed in treating rape-induced anxiety and phobic reactions. NLP theory suggests that anxiety reactions experienced by rape victims is a function of the inter-related processes of synesthesia and anchoring. A pair of case reports are presented which explore the use of the V-K Disassociation technique. From this preliminary bases, further research employing this treatment procedure is suggested. Implications for clinical practice are noted.

TABLE OF CONTENTS

Page

LIST OF TABLES

CHAPTER I

INTRODUCTION

The subject of rape and the treatment of rape victims has received surprisingly little attention in the field of psychology. Clinical practitioners, news media coverage, and common sense provide acknowledgement of the frequent occurrence of phobic reactions, interpersonal difficulties, sexual dysfunctions, depression, and anxiety associated with the aftermath of rape all of which are obvious problems of psychological concern.

In the past, psychiatrists have tended to be more interested in the rapists than in the victim. It was not until the later 1960's that researchers began to focus more upon the victim. Since then, research in the area has generated significant data showing that most rape victims develop psychological symptoms and related behavioral changes following the experience of rape (Katz & Mazur, 1979; Sutherland & Scherl, 1970; Burgess & Holmstrom, 1974; Ellis et al., 1981; Resick et al., 1981; Atkeson et al., 1982; Calhoun et al., 1982; Kilpatrick & Veronen, 1979).

The need for specific treatment strategies designed to address the psychological effects of rape is well documented (Kilpatrick, Veronen & Resnick, 1970; Burgess & Holmstrom, 1974). Three models which attempt to explain anxiety reactions experienced by rape

victims and to propose treatment modalities include crisis intervention, the cognitive-behavioral approach and Neuro-Linguistic Programming.

The Neuro-Linguistic Programming (NLP) model, a communication and behavioral model developed by Bandler & Grinder (1975), Grinder & Bandler (1976) & Dilts et al. (1980) is the focus of this study. Cameron-Bandler (1985) & Grinder & Bandler (1982), working within the NLP model, reported on the successful treatment of rape victims in employing a three-place Visual-Kinesthetic Disassociation.

The Problem

The intent of the present study was to explore the use of a specific procedure, NLP's Visual-Kinesthetic Disassociation, for the treatment of rape-induced anxiety and phobic reactions. No long range studies have been published on the effects of this technique. Theoretically and empirically, however, we know the need to regain mastery and control through re-accessing the trauma (Perls et al., 1951). The NLP three-place V-K Disassociation technique seems to satisfy this important requirement as well as being a gentle, no-obstrusive intervention as reported in the clinical experience of the researcher. Two case reports are presented to illustrate the V-K Disassociation procedure and to examine the application of this approach in the treatment of victims of rape. These two cases are intended to provide preliminary data from which recommendations can be made for clinical practice and for further research.

The decision to pursue this avenue of research was based on familiarity with the procedure as the present researcher has employed it for a number of years in a clinical setting. Past experiences with the procedure had yielded numerous reports from clients as to its effectiveness. Until the present effort, no attempt has been made to substantiate these reports. It was the intent of the present investigation to focus some light on the NLP three-place V-K Disassociation technique by examining two case studies which include data from standard measures as well as from counsellor/client interviews.

CHAPTER II

REVIEW OF RELATED LITERATURE

DESCRIPTIVE RESEARCH

Global Response Pattern

Initial research into the aftermath of rape focused primarily upon the identification of global response pattern. The first clinical study of rape victims was published in 1970 by Sutherland & Scherl. The authors interviewed thirteen rape victims and found similar response patterns among them. The Sutherland & Scherl study was followed by a second and similar study conducted by Burgess & Holmstrom (1974), based on interviews with 146 rape victims.

Both studies attempted to identify phases or sequential constellations of reactions as a result of the assault. The authors reported that victims perceive the event as life threatening and degrading; as having been violated and lost control over their life. The assault is experienced as an act of aggression and not as a sexual act. In adjusting to the event, victims go through a number of stages: (1) an acute stage of shock and anxiety; (2) a pseudo adjustment period characterized by denial and suppressions; and (3) a final stage in which symptoms begin to reappear (Sutherland & Scherl, 1970).

The initial research conducted by Sutherland and Scherl (1970) and by Burgess and Holmstrom (1974), was based on unstructured interviews which yielded rich descriptive data concerning the victims' global reaction to rape. Although not well-controlled or systematic, these studies provided information that has influenced subsequent research (Resick et al., 1981).

Research in the 1980's

Subsequent researchers on the after effects of rape have attempted to determine more precisely the extent, duration and specific aspects of functioning that have been effected. For example, social adjustment is disrupted in most areas initially, and by four months post-rape, social functioning stabalizes at levels comparable to non-victims (Ellis et al., 1981). Frank and Stewart (1983) observed significant levels of depression in victims up to six weeks post-rape while Atkeson et al., (1982) noted significant levels of depression up to four months post-rape. Significant levels of fear and anxiety were noted by Calhoun et al. (1982) up to one year post-rape as did Ellis et al. (1981) and Kilpatrick et al., (1979, 1980) while Veronen and Best (1983) in a review article of their work reported significant levels of fear and anxiety up to two years post-rape. Becker and Skinner (1983) reported that sexually assaulted women reported a higher incident of sexual problems than non-assaulted women. As well, their difficulties tended to be more frequently related to early sexual arousal while the non-victims

reported other types of sexual problems. Burgess and Holmstrom (1979) reported that some women (25.9%) did not consider themselves sexually recovered from the rape experience 4-6 years post-rape. Feldman-Summers et al., (1979) noted that by two months post-rape sexual functioning was still disrupted and the disruption of sexual functioning was a function of the rape experience and specific to the particular circumstances of the rape and not as originally thought a global response.

In summary, these researchers suggest that rape produces an overwhelming sense of fear, anxiety, helplessness, and powerlessness. It taxes the victim's coping capacity and constitutes a crisis situation. The resulting adaptive responses of the victims constitutes a recognizable constellation of behaviors referred to as the "rape trauma syndrome". (Burgess & Holmstrom, 1974). The syndrome is often marked by depression, guilt, anger, disruption in many aspects of the person's interpersonal life, sexual dysfunctions, phobic responses and a number of somatic reactions. These issues and problems appear to resolve themselves somewhere between one and three months without formal treatment leaving a core of fear, anxiety, sexual dysfunction and phobic responses which are stable over time and constitutes the most difficult task in the recovery process.

There are a number of problems associated with the cited research. Firstly, the majority of the research has been descriptive in nature. It has in other words attempted to explore and clarify the after-effects of rape. The research assumes without specifying, that the observed description in functioning are a result of the rape. Common sense and case study reports would lead one to accept the assumption but it must be tempered with the caution that there has been no comparative studies conducted comparing rape victims to victims of other forms of violent crimes. Whether one attributes the after-effects of rape to violent crime in general or to the rape per se is from a clinical and phenomeological perspective, purely academic. For if the victim attributes the after-effects to the rape ipsofacto, it becomes her reality and that of the clinitcan.

A second problematic area in the research is that of sample biases. Subjects for rape studies are selected from a number of sources and each source has a built-in biases which may greatly effect the results obtained. For example, Burgess & Holmstrom (1974) obtained their subjects from hospital emergency rooms. Cases seen in hospital emergency rooms are usually only those cases severe enough to require medical and/or psychiatric assistance and may represent only a small portion of rape victims. The failure of such a sample to accurately represent rape victims is underscored by the fact that rape is considered to be one of the most unreported

crimes. It has been estimated that anywhere from one and one-half to 100 times more rapes are committed than reported (Katz & Maxur, 1979). One has to question whether there exists any important differences between victims who report their cases or seek assistance in dealing with the rape after-effects and those who do not report or seek assistance.

A third methodological difficulty with the research is that of method invariance. The work of Sutherland & Scherl (1970) and of Burgess & Holmstrom (1974) used similar settings to select/solicit participants for their studies; they used similar approaches in gathering their data and found essentially similar results. Subsequent research has largely been premised upon the results of this earlier research. Many of these researchers have used similar survey instruments, have solicited participants in similar settings and have frequently been associated with each other.

The picture of the rape victim presented by these researchers must be questioned in terms of its representativeness and clarity. Unfortunately, it is the only available picture. It was presented not to specify and clarify the exact areas and extent of functioning that is disrupted by rape but rather to argue that rape disrupts functioning. It was presented to suggest that if a client presents herself as a rape victim, it is safe to assume that how she experiences the self and the world has been disrupted by that experiences. Which is a sufficient argument for the clinical and phenomenological perspective of the present researcher.

Explanatory Research

Three theoretical explanations for the observed after-effects of rape have emerged from the literature review: crisis theory, the cognitive-behavioral model and the Neuro-Linguistic Programming model.

Crisis Theory

In crisis theory, which had its origins in Linderman's (1944) work, rape is viewed as a crisis situation in which a traumatic external event disturbs the balance between internal ego adaption and the environment. As rape anxiety is considered to be an interaction between an extreme environmental stimulus and the adaptive capacity of the victim, this anxiety is similar to other stress situations such as community disaster, wars, surgery, automobile accident, loss due to suicide, loss of limb, etc. (Horowitz, 1976; Smith, 1970). Critical factors in rape, as in other events which are perceived as life-threatening, are the unexpectedness of the event and the victim's resources for coping (Notman & Nadelson, 1976). Crisis theory focuses on homeostatic balance and the relationship of coping processes to stable psychological functioning (Burgess & Holmstrom, 1981).

Crisis intervention is not conceptually a clear model of social intervention. It neither specifies nor suggests ways in which maladaptive behavior can be predicted, nor does it identify the mechanism whereby maladaptive behavior is learned or maintained. In fact, it appears that crisis theory has not changed dramatically from the pioneering contribution of Linderman. Theorists have not operationalized the crisis approach into a clear, conceptual treatment plan (Smith, 1970). Although crisis theory has generated considerable practical application of ideas in developing centers to assist traumatized victims, it has generated little if any significant empirical research.

Cognitive-Behavioral Model

The cognitive-behavioral model developed by Veronen and Kilpatrick (1983) views rape as an "'in vivo' classical conditioning situation in which the threat of death and/or physical damage, plain, and/or confinement evoke responses of cognitive,, physiological, and behavioral fear and anxiety" (p. 356). This approach focuses on the role of cognitive variables as determinants of a victim's responses. Thoughts associated with or generalized from the rape experience become conditioned stimuli for fear and anxiety. If the conditioned stimulus is adversive enough, one presentation can result in complete suppression of behavior or avoidance of cues that signal the fearful event (Resick & Jackson, 1976).

Various studies with a cognitive-behavioral orientation have been reported. Veronen and Kilpatrick (1983) used systematic desensitization and self-instruction training for treating rape-induced anxiety and phobic reactions. Forman (1980) reported on the successful use of Rational Emotive Therapy in trating rape victims. Blanchard and Abel (1976) successfully employed biofeedback in treating a rape-induced psychophysiological cardiovascular disorder.

Neuro-Linguistic Programming (NLP)

Neuro-Linguistic Programming (NLP) developed by Bandler and Grinder (1975), Grinder, & Bandler (1976), and Dilts et al., (1980) is a communication and behavior model based in the postulate that human beings do not operate directly on their world. They operate out of their internal maps and not out of sensory experience (Korzybski, 1958). According to NLP theory, human beings construct conceptual maps or series of maps that represent the world and are used to both guide behavior and to describe the world. These maps or representional systems are constructed from sensory experience -- visual, auditory, kinesthetic, gustatory and olfactory (Dilts, et al., 1980), and are particularly influenced in their development by parental programming and other environmental and physiological factors including shocks or trauma that result in one trial learning.

A central postulate of the NLP model is that problems arise not from any lack of personal internal resources or scarcity in the external world, but from a lack of organization and utilization of those resources. The assumption that people are basically whole and have a complete set of resources is fundamental in the work also of Erickson et al. (1976) and Satir (1972). Right orientation in these approaches is described by Carter (1983): "The goal is not to remove something bad or add something good, but rather to stimulate and organize the resources that are already inside the client's world" (p. 23). What is important in the meaning-making processes of this approach is not the content of a particular representation itself but rather its placement in the context of a particular sequence.

Parallel with constructivist theories (Von Foerster, 1981; Watzlawick, 1985) and the mutuality approach, NLP postulates that human experience is created and shaped, not only by external stimulus or force, but also, by changing one's sensory patterning of the world. Problems in the patterns and structures of cognitive maps may occur through the universal modeling processes of generalization, deletion, and distortion.

Generalization refers to the process whereby pieces or elements of a person's model become detached from the original experience and come to represent the entire category of which that particular experience is only an example. Deletion is the process whereby a

person pays selective attention to certain dimensions of experience and excludes others. Distortion is the process whereby people can make perceptual shifts in their experiences of sensory data (Bandler & Grinder, 1975).

For example, the experience with the rapist can come to stand for the experience with all males (generalization). Despite numerous subsequent positive experiences with males, this does not change (deletion). When caring family and friends point out discrepancies in logic or behavior, the process of (distortion) allows the inconsistency to remain, the model to remain intact, and the problem to remain unresolved.

The NLP model postulates that fear, anxiety, phobic responses and sexual dysfunction is a function of the inter-related processes of synesthesia and anchoring. Although NLP does not claim to have the know-how to predict specific anchor and synesthesia patterns involved in creating specific problems, techniques of NLP can be used to identify occurrences, generalizations and maintenance patterns in one's basic model or cognitive map as a first step for therapeutic intervention.

Synesthesia

Synesthesia is the correlation between representations in two different sensory systems that have become associated in time and space. For example, seeing blood and feeling nauseous is a visual-kinesthetic synesthesia: "Crossover connections between representational system complexes, such that the activity in one representational system initiates activity in another system is called synesthesia" (Dilts et al., 1980, p. 23). Such patterns constitute a large portion of the human meaning-making process. Correlations between representational system activities are at the root of such complex processes as knowledge accummulation, choice, and interpersonal communication.

Anchoring

Any representation, internal or external, which triggers another representation or series of representations is known as an anchor. In simple language, an anchor is any stimulus that has become associated with a response. The image of a snake may be an anchor for the response of fear. A basic assumption behind anchoring is that all experiences are represented as gestalts of sensory information. Whenever any portion of a particular experience is re-introduced, other portions of that experience will be reproduced to some degree. For example, a certain piece of music may trigger memories of a particular person or event. That event had become

associated with the music in previous experience: "They're playing our song dear!" Any portion of an experience may be used as an anchor to access another portion of that experience (Dilts et al., 1980).

Anchoring is similar to the "stimulus-response" concept in behavioristic models. There are, however, some important differences as outlined by Dilts et al., (1980): Rather than being conditioned over long periods of time, anchors promote the use of single trial learning. Reinforcement is not required to establish an anchor, and cognitive behavior is considered to be as much of a response as a salivating dog.

In terms of the methodology under investigation, the Visual Kinesthetic Disassociation assumes that fear, anxiety, and phobic responses associated with severe traumatic events are anchored responses. The overwhelming negative feelings associated with this past event can be triggered by present external or internal stimuli which have become anchored to the event. Further, if the association between the triggering stimuli and the internal responses can be altered, the phobic responses - fear and anxiety, will be eliminated. Finally, an alteration of this association presupposes an alteration of the map territory relationship.

A criticism frequently made of NLP is its lack of supportive research. Bandler & Grinder (1979) indirectly address the concern when they state, "We have no idea about the 'real' nature of things and we're not particularly interested in what's true" ... we're not offering you something that's true, just things that are useful" (p. 7). For the purpose of this study, it matters little if the proposition set forth by the originators of NLP have any basis in 'truth' or 'reality". What is important is the extent to which the model and the techniques are 'helpful' or 'useful', the determination of which is the focus of the present study.

The Visual-Kinesthetic Disassociation Procedure

The NLP methodology explored in the present study is the Visual-Kinesthetic Disassociation (V-K Disassociation). In utilizing this methodology, Bandler (1985) suggests that a therapist first notice whether the person is associated or disassociated in the memories, Associated means going back and relieving the experience, seeing it from one's own eyes. From a NLP perspective disassociated means looking at the memory image from any point of view other than from your own. You might see it as if looking down from an airplane or as if you were someone else watching a movie of yourself in the situation. In general, disassociation can be produced by shifting from a feeling to a visual mode. Disassociation can be increased by changing the size of an image, especially to make it smaller, or by increasing the distance between self and image.

The V-K Disassociation technique has been reported by Fromm (1965) and Fromm & Gardner (1979) who describe the procedure as separating or disassociating the observing ego from the experiencing ego. In this approach, a person can be described as being either in the picture or not in the picture of a personally accessed mental image indicating a two-place V-K Disassociation. Fromm (1965) maintains that in hypnosis, the observing ego can be so totally separated from the experiencing ego that pain is observed but not felt. As an example, a woman in labor is told to imagine herself walking down the hospital corridor toward the delivery room: "Let that woman who looks like you get ahead of you a few steps. She is dressed like you ... You sit on a chair in the corner of the delivery room and watch that woman have a baby" (p. 129). Fromm explains: "Ego cathexis remains with the observing ego ("you) watch ... you sit"), while the body is de-egotized and has became an object — "that woman" (p. 1129).

Bandler (1985) and Cameron-Bandler (1985) speak of three positions in the disassociation. The three place V-K Disassociation technique has been described as follows:

> It involves having a person watch himself from a third position; which allows him to watch himself watching himself going through the traumtic experience. In this way, the person can remain comfortable while still remembering the experience because the kinesthetic (feeling) portion is disassociated from the visual memory (Cameron-Bandler, 1985, p. 152).

In the NLP three-place disassociation, the visual perspective remains from the third position, ie., the actual physical self watching an image of self watching self. The second position is the image of self watching self in experience; and the first position is the image of self actually going through the event. Bandler (1985) uses the three-place procedures as follows:

> First I want you to imagine that you're sitting in the middle of a movie theater, and up on the screen you can see a black-and-white snapshot in which you see yourself in a situation just before you had the phobic response ... Then I want you to float out of your body up to the projection booth of the theater, where you can watch yourself watching yourself. From that position you'll be able to see yourself sitting in the middle of the theater, and also see yourself in the still picture up on the screen... (p. 43).

Cameron-Bandler (1985) offers the following example of a three-place disassociation:

> Now, Jessica, I want you to begin to float outside of your body to just in back of yourself so that you can see yourself sitting here next to me. See yourself holding my arm and watching the part of Jessica that needs help out in front. So you float outside until you can see Jessica next to me watching the younger Jessica out in front. You'll be watching yourself watching yourself. When you can see yourself here with me, nod your head (p. 155).

In the present study, the Visual Kinesthetic Disassociation technique consisted of the following steps:

1. Establish and anchor a sense of safety, comfort and resourcefulness in the client.
2. Holding the anchor, have the client visualize herself in a "still shot" of the first scene of the rape.
3. To get outside of the picture, have the client imagine herself floating out of herself and seeing herself sitting there looking at herself in the "younger" pre-rape state. This disassociation can be done as many times as is felt necessary to insure comfort. As such, there are now three visual perspectives: From the present day person, from the imaged person outside of the picture and from the imaged person in the picture.
4. The client is instructed to run through the experience visually. To insure that she remain comfortable at all times, use the anchor and the verbal patterns which indicate separation of the three parts.
5. When the experience has been visualized completely, have the second part float back into the actual present day person.
6. In her imagination, have the present day person do to the younger person and provide her with the information necessary to insure understanding and appreciation.

7. When the present day person sees that her younger self has been reassured, integrate the selves by instructing the client to bring that younger part back inside her own body.

Further elaboration and a sample counselling transcript illustrating the V-K Disassociation technique can be found in the book Solutions (1985) pp. 151-158.

The Question

A number of questions, including those to be examined in this study, are suggested by the preceeding discussion. The primary question being asked is the following: Is the V-K Disassociation procedure helpful in assisting non-recent (three months to two years) sexual assault victims in overcoming blocks to normal functioning? For the purposes of this study "blocks to normal functioning" will be held to mean any reported difficulty, symptom or problem that a subject is experiencing.

At three different points in this study an assessment was conducted to determine reported difficulties, problems and symptoms. Two methods were utilized to gather this information. The primary method employed was the structured interview. In keeping with the clinical orientation of this study the information gathered in this way is considered to be of primary importance and to have the most reliability and validity. The second method

utilized was that of standard measures. This data was gathered to provide a background upon which to view the interview data. It is thus to be considered as secondary and supplemental only. It is intended, in other words, to be used as an external criteria to assist in analyzing and understanding the interview data.

CHAPTER III

DESIGN AND PROCEDURES

Procedure

The study was conducted utilizing a two-step treatment procedure and three assessment periods. The subjects reported no treatment prior to these interventions.

Procedure

Selection of Participants: The subjects for this study were contacted through an advertisement placed in a university student newspaper. The advertisement read as follows: "Sexual assult victims experiencing anxiety problems are required for a research/treatment project. Please call.....". Responses were received from both males and females. As the research upon which this study was based dealt exclusively with female rape victims, the male respondents were excluded from the study. As well those female respondents who were more than 24 months post-rape were excluded for the same reason. Of the respondents to the ad, only two were found suitable under the above conditions and willing to participate in the study.

All sessions were conducted by the same therapist at a university counselling facility.

Hypnosis

Hypnosis can be used adjunctively in the context of many theoretical framewords of psychotherapy. The use of hypnosis coupled with the V-K Disassociation has been suggested Bandler (1985), Cameron-Bandler (1985). With this possibility in mind, processs of naturalistic trance formation were utilized (Erickson & Rossi, 1981) in the present study. In using the naturalistic approach, no screening for ability of suggestion is necessary.

In an effort to ensure consistency, a hypnotic induction procedure was read to each subject (see Appendix 1). This procedure was compiled from examples of the Erickson's approach to hypnotic induction (Erickson and Rossi 1981, p. 66 - 106). Presentation of such an induction is consistent with that normally used in research involving hypnosis (Adolf, 1981).

Pre-Treatment Session: The pre-treatment session consisted of providing subjects with information about the study, an assessment interview, and completion of the assessment package. Each subject was interviewed individually for approximately one and one-half hours.

Session A: Each subject was interviewed individually for approximately one and one-half hours, one week after the pre-treatment session. Trance induction was established for the purpose of creating a positive anchor of relaxation, safety, trust, resourcefulness, comfort and confidence. An opportunity was provided for questions and discussion of procedure.

Session B: Subjects were interviewed one week after session A. They were asked to complete the assessment package first. The induction procedure was administered prior to the V-K Disassociation procedure to access the previously established positive anchors. Slight variations in trance-inducing procedure were necessary to accommodate the individual and her particular way of learning. At this time, an opportunity was provided for questions and discussion of procedure. Each subject was interviewed for approximately two hours.

Post Treatment: Three weeks after session B, subjects were interviewed individually for approximately one and one-half hours. During this session, subjects were asked to complete the assessment package and to provide a subjective evaluation of the procedures and the impact on their level of anxiety in daily living.

Assessment Package: The assessment package consisted of the following instruments which have been used in previous research dealing with rape victims: SCL-90-R (Derogatis, 1983); the Veronen-Kilpatrick Modified Fear Survey (MFS-II) (Veronen & Kilpatrick, 1983); Profile of Mood States (POMS) (McNair et al., 1981) and the State-Trait Anxiety Inventory (Form Y) Self Evaluation Questionnaire (STAI) (Spielberger, 1983). Its inclusion was based on the need to evaluate the methodologies through the integration and data from both interviews and standard measures. Appendix II contains a detailed description of each of the intruments and scales used and a summary of overall evaluative research.

The small sample utilizied in this study procludes the statistical analysis of the standard measures data and necesitates a reliance upon clinical judgement to interpret the data. To insure consistency and meaningfullness in such judgements, and in keeping with clinical practices, only changes of one or more standard deveations will be considered substantial or meaningful. As well only those meausres that are more than one standard deveation above or below the norm will be deemed meaningful.

CHAPER IV

CASE STUDIES AND FINDINGS

Case Studies

Subject I

Background

Subject I was a 19-year old Caucasian woman who was enrolled in her third year of a B.A. program at the time of entering treatment. She had been raped approximately 20 months previously while at a party by a man whom she knew. She did not inform the police for fear of not being believed, and told only her mother and her boyfriend about the rape. Subject I indicated that the rape-induced fears had been problamatic for approximately one year prior to entering treatment. She had noted that she was very angry and fearful with people she did not know well. She reported feeling very uncomfortable around males and noticed herself being very confrontative with them. Subject I found herself having little patience to listen to her friends when they approached her with personal problems which she stated was very much out of character for her. Subject I reported being concerned about losing control of her behavior and noted that her emotional responses were often excessive. She found herself preferring female companions to male companions and developing more "feminist" perspectives on many issues. Subject I noted that she frequently found herself "turning

off" during sexual relations and could only become sexually responsive if she initiated the event. She reported that her primary reason for entering treatment was to overcome the rape so that she could give "100%" of herself to a relationship. In her present relationship she felt as if she could not choose to do so.

Treatment Outcomes

Interview Data

Treatment followed the previously described format. By the end of treatment, Subject I reported feeling more relaxed and energetic. She reported being able to talk about rape if the subject came up and feeling less "jumpy" and more comfortable around males. She felt a decreased sense of personal responsibility for the rape and when she thought about it could see it objectively and with little accompanying negative affect. She reported feeling more confident, secure, and sexually responsive. She found that she no longer needed to initiate sexual relations in order to be responsive. Subject I reported feeling that she could now choose to give "100%" to a relationship should the opportunity present itself. When asked how helpful she had found the course of treatment, Subject I stated that she had found it to be very helpful. She felt that she still had things to overcome but knew that she could, over time, deal with them.

Standard Measures Data

In analysing the standard measures data it was decided that only those scores above or below the norm one or more standard deviations would be considered to be of clinical importance or to be meaningful in a clinical way. Further that only those scores which changed one or more standard deviations would be considered to be clinically meaningful.

State Trait Anxiety Inventory (STAI)

Analysis of Subject I's pre-treatment anxiety levels as reflected by the STAI revealed that both the A-State and A-Trait score were elevated (see Table I). The A-State score was elevated 1.27 standard deviations above the norm. The A-Trait score was elevated slightly by 0.94 standard deviations above the norm.

Assessment one week after receiving session A revealed a general pattern of improvement. The A-State and A-Trait scores continued to be elevated but only slightly. In contrast to pre-treatment levels the A-State score had decreased by 1.0 standard deviations. The A-Trait score had decreased by 0.59 standard deviations.

Assessment three weeks after receiving treatment session B revealed a continued pattern of improvement. Both scores were now within normal range. The A-State score had decreased by 0.84 standard deviations and the A-Trait score had decreased by 0.89 standard deviations. These decreases were considered too small to be clinically meaningful.

TABLE I

ANXIETY (STAI), FEAR (MFS) MOOD STATE (PMOS) AND SYMPTOM (SCL 90R) SCORES OF SUBJECT I ACROSS ALL THREE ASSESSMENT PERIODS

Dependent Measure	Norm Score	Pre-Treatment	Session A	Session B
STAI				
A-State	38.76 (11.95)*	54	42	32
A-Trait	40.40 (10.15)	50	44	35
MFS				
Animal	17.85 (6.88)	23	23	24
Tissue	37.15 (15.64)	50	45	49
Classical	28.25 (8.81)	29	32	30
Social	32.75 (10.08)	40	43	37
Miscellaneous	21.5 (7.32)	28	24	24
Failure	32.55 (11.17)	39	35	35
Rape	79.45 (27.75)	103	77	110
Overall	218 (70.03)	312	279	309
PMOS				
Tension	50 (10)	54	43	45
Depression	50 (10)	53	45	42
Anger	50 (10)	76	48	45
Vigor**	50 (10)	49	44	55
Fatigue	50 (10)	54	49	43
Confusion	50 (10)	57	46	46
SCL90-R				
Som	.36 (.42)	.9	.92	.08
OC	.39 (.45)	1.9	1.44	1.1
IS	.29 (.39)	1.89	1.22	.89
DEP	.36 (.44)	2.08	1.30	0.3
ANX	.30 (.37)	1.33	1.00	0.9
HOS	.30 (.40)	2.17	0.17	0.17
PHOB	.13 (.31)	0.57	0.14	0.14
PAR	.34 (.44)	2.67	1.33	0.67
PSY	.14 (.25)	0.44	0.50	0.10
GSI	.31 (.31)	1.35	0.89	0.48
PSDI	1.32 (.42)	2.14	1.40	0.83
PST	19.39 (15.48)	57	57	36

*Standard Deviations in Brackets
**Indicates A Positive Dimension

Sources: Derogatis, 1983; McNair et al., 1981; Spielberger, 1983; and Kilpatrick et al., 1979.

Over the course of treatment Subject I's A-State score had decreased by 1.84 standard deviations. The A-Trait score had decreased by 1.47 standard deviations. The data from the scales used tend to suggest changes occurred over the course of treatment.

Modified Fear Survey II (MFS II)

Analysis of Subject I's level of fear as reflected by the MFS II at the pre-treatment assessment period revealed that only the Overall Fear score was elevated more than one standard deviations above the norm (see Table I).

One week after receiving session A analysis of Subject I's MFS II scores revealed that only minimal change had occurred. In contrast to pre-treatment levels minor decreases in score were noted for Tissue Damage Fears, Miscellaneous Fears, Rape-Related Fears and Overall Fears. Minor increases in Classical Fears, and Social Fears were observed while The Animal Fears scale had remained unchanged.

Assessment three weeks after receiving session B in contrast to session A levels revealed a slight increase in reported fears. The Rape Fears score had increased marginally to become elevated 1.1 standard deviations above the norm. The Overall Fear score had also increased slightly to become elevated 1.3 standard deviations above the norm. Slight increases were also observed in The Animal Fears and Tissue Damage Fears. The Miscellaneous Fears and Fear of Failure scales had remained unchanged and minor decreases were noted in the Classical Fears and Social Fears scales.

Over the courses of treatment minor decreases were observed in all scales except Animal Fears and Rape-Related Fears. The data from the scales used tend to suggest that the course of treatment did not affect Subject I's level of fears as reflected by the MFS° II in any clinically meaningful way.

Profile of Mood States (POMS)

Analysis of Subject I's mood state as reflected by the scales of the POMS at the pre-treatment assessment period indicated that all of the scales except Vigor were elevated (see Table I). Of these, only the Anger scale which was 2.6 standard deviations above the norm was considered to be clinically elevated. The Vigor scale which reflects a positive dimension was depressed but only slightly.

Analysis one week after receiving session A in contrast to pre-treatment levels indicated improvement in all the scales except Vigor. The Vigor scale had fallen slightly by 0.5 standard deviations. Decreases were observed in the Tension, Anger and Confusion scales which dropped 1.1, 2.8 and 1.1 standard deviations respectfully. The decreases in the Depression and Fatigue scale of only 0.8 and 0.5 standard deviations respectively were not considered to be clinically meaningful.

Assessment three weeks after receiving session B in contrast to session A levels revealed a general pattern of improvement. The Tension scale had increased modestly by 0.2 standard deviations. The Confusion scale remained unchanged and within normal range. The Depression, Anger and Fatigue scales had each decreased slightly by 0.3 standard deviations each. The Vigor scale, a positive dimension, had risen by 1.1 standard deviations.

Over the course of treatment the following decreases in number of standard deviations were observed: Tension 0.9, Depression 1.1, Anger 3.1, Fatigue 1.1 and Confusion 1.1. The positive Vigor scale had increased by 0.6 standard deviations. The data from the scales used tend to suggest that changes occured over the courses of treatment in all scales except for the Tension and Vigor scales.

SCL-90-R

Analysis of Subject I's SCL-90-R symptom profile at the pre-treatment assessment period revealed that all of the scales and global indices of distress were elevated more than one standard deviation above the norm (see Table I).

Assessment one week after receiving session A, in contrast to pre-treatment levels, revealed a general pattern of improvement. Of the nine scales and three global indices of distress, only two scales and one global indice of distress failed to show improvement. The two scales which had not shown improvement were the Somatization and Psychoticism scales which had increases by 0.04 and 0.24 standard deviations respectfully. The Positive Symptom

Total global indice of distress had remained unchanged. The Hostility and Phobic Anxiety scales at decreased by 5.0 and 1.39 standard deviations respectfully and were now within normal range, that is within one standard deviation of the norm. The Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Paranoid Ideation, Global Severity Index and the Positive Symptom Distress Index had decreases by 1.02, 1.72, 1.77, 1.0, 3.04, 1.48, and 1.76 standard deviations respectively and remained one or more standard deviations above the norm.

Three weeks after receiving session B assessment indicated that all the scales except for Obsessive-Compulsive, Interpersonal Sensitivity and Anxiety were within normal range. In contrast to session A the Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Paranoid Ideation, Psychoticism, Global Severity Index, Positive Symptom Distress Index and the Positive Symptom Total Index had all decreases by 2.0, 0.75, 0.85, 2.27, 0.3, 1.50, 1.60, 1.32, 1.36, and 1.36 standard deviations respectfully.

Over the course of treatment the following decreases in number of standard deviations were observed: Somatization 1.96, Obsessive-Compulsive 1.78, Interpersonal Sensitivity 2.56, Depression 4.04, Anxiety 1.30, Hostility 5.00, Phobic Anxiety 1.39, Paranoid Ideation 4.54, Psychoticism 1.36, Global Severity Index 2.81, Positive Symptom Distress Index 3.12, Positive Symptom Total 1.36. The data from the scales used tend to suggest changes occured over the courses of treatment.

Summary

At the pre-treatment assessment period Subject I reported clinically elevated scores on the following dependent measures: the A-State scale of the STAI, the Anger scale of the POMS, the Overall Fears score of the MFS II and all scales of the SCL-90-R. At this assessment period Subject I reported clinically elevated scores on 15 of the 28 dependent measures.

One week after receiving session A, Subject I reported elevated scores which were clinically meaningful on the following ten dependent measures: the Somaization, Interpersonal Sensitivity, Depression, Anxiety, Paranoid Ideation, Psychoticism, Global Severity Index, Positive Symptom Distress Index and Positive Symptom Total scales of the SCL-90-R.

Three weeks after receiving session B, Subject I reported elevated scores which were clinically meaningful on the following six dependent measures: The Rape-Related Fears and Overall Fears scales of the MFS II and the Obsessive-Compulsive, Interpersonal Sensitivity Anxiety and Positive Symptom Total scales of the SCL-90-R.

Over the course of treatment there had been a reduction of one or more standard deviations in reported levels of distress on the following dependent measures: The A-State and A-Trait scales of the STAI, the Depression, Anger, Fatigue and Confusion scales of the POMS and all nine scales and three global indices of distress of the

SCL-90-R. Of the 28 dependent measures, 18 were judged to have been clincially affected over the course of treatment.

Subject II

Background

Subject II was an 18-year, 11-month old Caucasian woman who was enrolled in her second year of a B.Sc. program at the time of entering treatment. She was the oldest of two children and came from a middle-class background. She had been sexually assaulted while on her way home from school when she was 10 and had been raped by a young man while on their first date approximately 18 months prior to entering treatment.

The sexual assault occurred while Subject II was walking home from school. The assailant grabbed her from behind, forced her into his car, drove her out-of-town on a gravel road at a high rate of speed and sexually assaulted her in what Subject II thinks was an empty school yard. He then drove her home, gave her some money and told her not to tell anyone what had happened. Subject II reported the assault to her parents who called police. Subject II did not provide her parents nor the police with as much detail about the assault or the assailant as she could have. In retrospect, Subject II indicated that she thought this was because of her sense of responsibility and of having somehow done something "bad." Subject II indicated that she found herself becoming extremely fearful whenever she was riding on a gravel road or in a car driven fast.

As well, she found herself over-reacting with fear whenever she was approached from behind. Subject II could not identify any other behavior which she felt were connected to the sexual assault.

The rape occurred approximately 18 months prior to entering treatment. Subject II did not report it nor did she tell anyone about having been raped. The rape occurred in a park after her assailant had been drinking. Subject II indicated that she was able to overcome the rape experience for approximately a year. She then began to notice a sense of distrust of men and a fear of being with them which became more pronounced if they had been drinking. As well, she noticed a general tendency to be nervous and short-tempered with anyone she did not know. Subject II found herself usually sitting with her back to a wall in public and could not tolerate sitting in a movie theater unless she was in the back row. Subject II reported feeling a lack of control in her life and a need to constantly be on guard. She indicated that she decided to seek treatment because of her constant worry that her boyfriend would assault her even though he had never given her any cause to worry and despite her constant attempts to reassure herself of this.

Treatment Outcomes

Interview Data

The initial assessment session revealed that Subject II had experienced two assaults that had apparently produced distinct patterns of fear. It was decided that treatment would follow the previously described format with the addition of one more session involving trance plus V-K Disassociation to deal with the second and most recent assault. Subject II chose to terminate treatment after only one session of trance and V-K disassociation aimed at dealing with the first sexual assault only.

Subject II reported that treatment session A, trance only, produced a marked change in her "trust" level and comfort level around males. Between session, Subject II had attended a dance in which she had found herself sitting comfortably with males she had recently met. As well, she reported feeling less angry and "snappy with people."

During treatment session B, the sexual assault that had occurred when she was 10 was dealt with. Between sessions, Subject II went on a ski trip during which she learned to ski. Upon her return she surprisingly indicated a desire to terminate treatment. When questioned as to why, Subject II indicated that she had dealt with the second assault on her own and thus no longer required treatment. She indicated that learning to ski had been a very strong metaphor for learning how to overcome her rape-related fears. She stated that the V-K had taught her how to overcome her

fears and that she had applied this learning to the second assault. She stated that she found herself no longer "pre-judging" people and that family and friends had commented on how she seemed "happier" and more relaxed. Subject II felt more in control of her life and that she now had more choices available to her. Subject II reported that she no longer over-reacted when approached from behind or felt so "scared" in unfamiliar situations.

Standard Measures Data

State Trait Anxiety Incentory (STAI)

Analysis of Subject II's pre-treatment anxiety levels as reflected by the STAI revealed that both scores were within normal range (see Table II).

Assessment one week after receiving session A indicated that the A-State score had decreased slightly and that the A-Trait score had increased slightly. Both scores continued to fall within normal range.

Assessment three weeks after receiving session B revealed that the A-State score had decreased slightly and that the A-Trait score had decreased by 1.08 standard deviations. Both scores continued to fall within normal range.

Over the course of treatment there had been slight decreases in reported levels of anxiety as reflected by the STAI. The A-State score had decreased by 0.92 standard deviations and the A-Trait score had decreased by 0.49 standard deviations. As only minor changes in the scores were observed the course of treatment did not appear to have affected Subject II's reported anxiety level in a clinically meaningful way. The courses of treatment was not expected to have affected reported anxiety levels given that they were within normal range at the pre-treatment session.

TABLE II

ANXIETY (STAI), FEAR (MFS) MOOD STATE (PMOS) AND SYMPTOM (SCL 90R) SCORES OF SUBJECT II ACROSS ALL THREE ASSESSMENT PERIODS

Dependent Measure	Norm Score	Pre-Treatment	Session A	Session B
STAI				
A-State	38.76 (11.95)*	33	30	32
A-Trait	40.40 (10.15)	40	46	35
MFS				
Animal	17.85 (6.88)	16	16	17
Tissue	37.15 (15.64)	37	25	22
Classical	28.25 (8.81)	32	23	18
Social	32.75 (10.08)	48	33	29
Miscellaneous	21.5 (7.32)	29	16	16
Failure	32.55 (11.17)	47	28	25
Rape	79.45 (27.75)	92	63	50
Overall	218 (70.03)	301	204	177
PMOS				
Tension	50 (10)	51	45	41
Depression	50 (10)	56	49	40
Anger	50 (10)	80	61	47
Vigor**	50 (10)	49	65	59
Fatigue	50 (10)	38	37	34
Confusion	50 (10)	48	46	39
SCL90-R				
Som	.36 (.42)	.33	.42	.50
OC	.39 (.45)	1.50	.40	.30
IS	.29 (.39)	1.40	1.11	.33
DEP	.36 (.44)	1.92	0.92	.30
ANX	.30 (.37)	1.80	1.20	.20
HOS	.30 (.40)	3.50	1.67	.50
PHOB	.13 (.31)	1.00	.29	0.00
PAR	.34 (.44)	1.17	.67	.33
PSY	.14 (.25)	.7	0.00	0.00
GSI	.31 (.31)	1.41	.68	.21
PSDI	1.32 (.42)	2.15	1.69	.79
PST	19.29 (15.48)	59	36	24

*Standard Deviations in Brackets
**Indicates A Positive Dimension

Sources: Derogatis, 1983; McNair et al., 1981; Spielberger, 1983; and Kilpatrick et al., 1979.

Modified Fear Survey II (MFS II)

Analysis of Subject II's reported pre-treatment fears as reflected by the MFS II revealed the Animal Fears, Tissue Damage Fears, Classical Fears and Rape Related Fears were within normal range while the Social Fears, Miscellaneous Fears, Fear of Failure and Overall Fears scales were 1.59, 1.02, 1.29, and 1.18 standard deviations respectfully above the norm (see Table II).

Assessment one week after receiving treatment session A revealed that all of the scores were within normal range. The Animal Fears score had remained unchanged. In contrast to pre-treatment levels the following decreases in numbers of standard deviations were observed: Tissue Damage Fears 0.77, Classical Fears 1.02, Social Fears 1.49, Miscellaneous Fears 1.77, Fear of Failure 1.70, Rape-Related Fears 1.06 and Overall Fears 1.38.

Three weeks after receiving session B assessment revealed that all of the score continued to fall within normal range. Minor decreases in fear levels were observed in all scales except Miscellaneous Fears which remained unchanged and Animal Fears which had increased slightly.

Over the course of treatment there had been a clinically meaningful reduction in reported levels of fears for all scales except Animal Fears which had increased by 0.14 standard deviations, and Tissue Damage Fears which had decreased by 0.96 standard deviations. The following decreases in numbers of standard deviations were observed: Classical Fears 1.56, Social Fears 1.88,

Miscellaneous Fears 1.77, Fear of Failure 1.97, Rape-Related Fea 1.51 and Overall Fears 1.77. The data from the scales used tend to suggest that changes occured over the courses of treatment.

Profile of Mood States (POMS)

Assessment of Subject II's mood state as reflected by the POMS at the pre-treatment assessment period revealed an Anger score that was elevated approximately 3.00 standard deviations above the norm (see Table II). Only an approximation can be made as the score obtained exceeded the upper limit of the scale. The Fatique scale was 1.2 standard deviations below the norm. All [illegible] were within normal range.

Assessment one week after receiving session A in contrast to pre-treatment levels revealed a general pattern of improvement. The Tension, Depression Confusion scales had decreased slightly and continued to be within normal range. The Anger scale had decreased by 1.9 standard deviations . The positive Vigor dimension had increased by 1.6 standard deviations and was now elevated 1.5 standard deviations above the norm. The Fatigue scale had decreased slightly and continued to be below normal range.

Assessment three weeks after receiving session B in contrast to session A levels revealed a continued pattern of improvement. The Tension and Depression scales had decreased slightly and continued to be within normal range. The Anger scale had decreased by 1.4 standard deviations and was now within normal range. The positive

Vigor dimension had decreased slightly and continued to be clinically elevated. The Fatigue scale had decreased slightly and continued to be more than one standard deviation below the norm. The Confusion scale had decreased slightly and was now more than one standard deviation below the norm.

Over the course of treatment the following decreases in numbers of standard deviations were observed: Tension 1.0, Depression 1.6, Anger 3.3, Fatigue 1.04, and Confusion 0.90. The Vigor scale which reflects a positive dimension increased by 1.00 standard deviations. The data from the scales used tend to suggest changes occured over the courses of treatment.

SCL-90-R

Analysis of Subject II's reported pre-treatment symptoms as reflected by the SCL-90-R revealed that all the scales exceeded the normal range except for Somatization (see Table II).

In contrast to pre-treatment levels assessment one week after receiving session A revealed a general pattern of improvement. There had been decreases in all scores except Somatization which had increases slightly but continued to be within normal range. The following decreases in numbers of standard deviations were observed: Obsessive-Compulsive 2.44, Interpersonal Sensitivity 0.74, Depression 2.27, Anxiety 1.62, Hostility 3.32, Phobic Anxiety 2.29, Paranoid Ideation 1.14, Psychoticism 2.8, Global Severity Index 1.48, Positive Symptom Distress Index 1.09, and the Positive Symptom

Total 1.48. The Obsessive-Compulsive, Phobic Anxiety, Paranoid Ideation, Global Severity Index, and Positive Symptom Distress Index were now within normal range and the Psychoticism scale was reported as symptom free.

Assessment three weeks after receiving session B, in contrast to session A levels revealed that the Somatization scale had increased slightly but continued to be within normal range. The Psychotisim scale continued to be reported as symptom free as was the Phobic anxiety scale and that all of the remaining scales were now within normal range. The following decreases in numbers of standard deviations were observed: Obsession-Compulsive 0.22, Interpersonal Sensitivity 2.00, Depression 1.40, Anxiety 2.70, Hostility 2.90, Phobic Anxiety 0.93, Paranoid Ideation 0.77, Global Severity Index 1.52, Positive Symptom Distress Index 2.14 and the Positive Symptom Total Index 0.77.

Over the course of treatment decreases in scores were observed for all scales except Somatization which had increased slightly by 0.40 standard deviations. The following decreases in numbers of standard deviations were observed: Obsessive-Compulsive 2.66, Interpersonal Sensitivity 2.74, Depression 3.68, Anxiety 4.32, Hostility 6.25, Phobic Anxiety 3.22, Paranoid Ideation 1.91, Psychoticism 2.8, Global Severity Index 3.87, Positive Symptom Distress Index 3.24, Positive Symptom Total 2.26. The data from the scales used tend to suggest changes occured over the courses of treatment.

Summary

At the pre-treatment assessment period, Subject II reported elevated scores which were clinically meaningful on the following dependent measures: Social Fears, Miscellaneous Fears, Fear of Failure and the Overall Fears scales of the MFS II, the Anger scale of the POMS, and all of the scales of the SCL-90-R except Somatization. Elevated scores were thus reported by Subject II on 16 of the 28 dependent measures.

One week after receiving session A, Subject II reported elevated scores which were clinically meaningful on the following six dependent measures: the Anger scale of the POMS, and the Interpersonal Sensitivity, Depression, Anxiety, Hostility and Global Severity Index of the SCL-90-R.

Three weeks after receiving session B, assessment indicated that Subject II did not report any non-positive scales as elevated in a clinically meaningful way.

Over the course of treatment there had been a clinically meaningful reduction in reported levels of distress on the following dependent measures: the Classical Fear, Social Fears, Miscellaneous Fears, Fear of Failure, Rape-Related Fears, and Overall Fears scales of the MFS II; Tension, Depression and Anger scales of the POMS; and all of the scales of the SCL-90-R except Somatization. As well, the positive Vigor dimension of the POMS had been affected in a positive direction. Of the 28 dependent measures, 21 had been affected over the courses of treatment in a clinically meaningful way.

Conclusion

The results obtained from both the interview and standard measures data suggest that the courses of treatment was helpful in assisting subjects to overcome blocks to normal functioning. At the pre-treatment assessment period, Subject I reported feeling angry and fearful of people. She reported feeling on edge around males and that she was concerned about excessive emotional responses, especially anger, and about losing control over her behavior. Subject I was, in other words, reporting that she was experiencing a great deal of distress. On the standard measures, Subject I, presented a similar picture, that of someone experiencing a great deal of distress. Specifically, that of the 28 variables being measured, 15 were reported as being elevated more than one standard deviation above the norm.

Three weeks after session B Subject I reported feeling more comfortable around males, more confident, secure and sexually responsive. As well, she reported feeling less responsible for the rape and more capable of talking about it. She also indicated that although she still had things to work on she could do so without further assistance. At the post-treatment assessment period or three weeks after session B in contrast to the pre-treatment assessment period, Subject I was presenting a picture of someone who

was experiencing substantially less distress. A similar picture was reflected by the standard measures data. Of the 28 dependent measures only 6 were reported as being elevated more than one standard deviation above the norm.

At the pre-treatment assessment period Subject II reported feeling anxious, short-tempered with strangers and distrustful of men. She felt that she needed to be constantly on guard and experienced a lack of control in her life. The high level of distress reported by Subject II during the structured interview was also reflected in the standard measures. Of the 28 dependent measures 16 were reported as being elevated more than one standard deviation above the norm.

During the interview one week after session B Subject II presented herself as feeling less angry and "snappy with people." As well she reported feeling more comfortable around males. This presentation of herself as experiencing less distress in her life was also reflected in the standard measures data. Of the 28 dependent measures only 6 were reported as being elevated more than one standard deviation above the norm.

Three weeks after session B Subject II reported feeling more relaxed, and happier. She indicated that she now felt more in control of her life, less fearful in unfamiliar situations and that she wished to terminate treatment. The standard measures data also indicated that further treatment was not warranted. Of the 28 dependent measures only one, a positive dimension, was reported as being elevated more than one standard deviation above the norm.

The intent of this study was to determine the effectiveness of the treatment procedure. Table III presents in numbers of standard deviations the extent of emotional distress reported by each subject over all the assessment periods. It displays a picture of decreasing reports of emotional distress and lends support to the primary evaluative sources, the interview data, and the conclusion of the positive effects of the course of treatment.

TABLE III

NUMBER OF STANDARD DEVIATIONS SUBJECTS SCORES WERE ABOVE THE NORM FOR EACH ASSESSMENT PERIOD

Dependent Measure	Pre-Treatment		Session A		Session B	
	Sub I	Sub II	Sub I	Sub II	Sub I	Sub II
A-State	1.27	- .48	.27	- .73	- .56	-1.4
A-Trait	.94	- .004	.39	.58	- .5	- .49
Animal	.75	- .27	.75	- .27	.89	- .12
Tissue	.82	- .009	.5	- .77	.75	- .96
Classical	.08	.42	.42	- .59	.2	-1.16
Social	.72	1.59	1.02	.02	.42	- .37
Miscellaneous	.89	1.02	.34	- .75	.34	- .75
Failure	.56	1.29	.22	- .4	.22	- .67
Rape	.85	.45	-.09	- .59	1.1	-1.06
Overall	1.34	1.18	1.34	- .2	1.3	- .58
Tension	.4	.1	-.7	- .5	- .5	- .9
Depression	.3	.6	-.5	- .1	- .8	-1.0
Anger	2.6	3+	-.2	1.1	- .5	- .3
Vigor*	-.1	- .1	-.6	1.5	.5	.9
Fatigue	.4	-1.2	-.1	-1.3	- .7	-1.6
Confusion	.7	- .2	-.4	- .4	- .4	-1.1
SOM	1.28	- .07	1.33	.14	- .67	.33
OC	3.35	2.47	2.33	.02	1.58	- .2
IS	4.1	2.85	2.38	2.1	1.54	.1
DEP	3.91	3.54	2.14	1.27	- .14	- .14
ANX	3.12	4.05	2.12	2.43	1.82	- .27
HOS	4.67	6.75	-.32	3.42	- .32	.5
PHOB	1.42	2.8	.03	.5	.03	- .42
PAR	5.29	1.89	2.25	.75	.75	- .02
PSY	1.2	2.24	1.44	- .56	- .16	- .56
GSI	3.35	2.68	1.89	1.19	.55	- .32
PSDI	1.95	1.98	.19	.88	-1.17	-1.26
PST	2.43	2.56	2.43	1.08	1.1	.3

* Denotes a Positive Dimension

CHAPTER V

DISCUSSION AND IMPLICATIONS

The primary objective of the present study was to investigate the effectiveness or usefulness an NLP technique V-K Disassociation for assisting non-recent rape victims to overcome the primary blocks to normal functioning this is fear and anxiety. Two case reports are presented to illustrate the V-K Disassociation procedure. These two cases are intended to provide preliminary data from which recommendations can be made for clinical practice and for further research. Only limited research has been published on its effects and none have attempted to integrate both interview data and standard measures.

In this chapter, a summary of the research is outlined and is followed by a discussion of the results obtained in relation to both the objective of the study and in terms of some of the theoretical and practical issues in the area of clinical work with rape victims. Following the discussion, a number of implications for further research and counselling are outlined.

Summary

The literature review suggested that victims of rape experience an overwhelming sense of fear, anxiety, helplessness and powerlessness. The resulting adaptive responses of the victims constitutes a recognizable constellation of behaviors referred to as the "rape trauma syndrome." The syndrome is often marked by depression, guilt, anger, disruption in many aspects of the person's interpersonal life, sexual dysfunctions, phobic responses and a number of somatic reactions. These issues and problems appear to resolve themselves somewhere between one and three months without formal treatment leaving a core of fear, anxiety, sexual dysfunction and phobic responses which are stable over time and constitute the most difficult task in the recovery process.

In attempting to explain these observations, three theoretical models have been forwarded: crisis intervention the cognitive-behavioral approach and the NLP model. Crisis theory views rape as a crisis situation in which a traumatic external event disrupts the balance between internal ego adaption and the environment. Crisis are considered to be self-limiting events in which a resolution, either adaptive or maladaptive, takes place within four to six weeks. Maladaptive responses are seen as being a result of the victim having learned self-defeating or neurotic mechanisms to cope

with the stressfull event. Crisis theory does not specify nor suggest ways in which maladaptive behaviors can be predicted, nor does it specify the mechanism whereby maladaptive behavior is learned or maintained.

The cognitive-behavioral model suggests that the extreme terror which precedes and accompanies a rape is sufficent to condition one-trial learning. As a result of this conditioning process, latter presentation of cues that are associated with the experiences trigger fear responses. Long-term fear and anxiety problems are thus seen as being acquired largely through classical conditioning, stimulus generalization and second-order conditioning. Cognitive stimuli as well as external cues can serve as conditioned stimuli for electing fear and anxiety responses.

The NLP model suggests that the fear, anxiety and phobic reactions experienced by rape victims is a function of the inter-related processes of anchoring and synesthesia.

Little information exists in the literature regarding the treatment of rape-induced problems and even fewer studies are devoted to treatment outcomes. The treatment modality most frequently offered recent victims is a modified form of crisis intervention based on the work of Burgess and Holmstrom (1974). This approach is short-term, issue-oriented counselling which focuses the initial interview and follow-up sessions on the rape incident itself. The goal of therapy here is to return the victim as quickly as possible to the pre-rape level of functioning. Crisis

counselling with rape victims is considered by some as a preventative form of therapy (Resick and Jackson, 1976). It is hoped that by assisting the rape victim in coping with the trauma of rape, maladaptive responses or beliefs will be avoided or minimized.

The short-term issues-orientated model developed by Burgess and Holstrom (1974) and adopted by many clinicians both professional and lay, lacks emperical verification of its effectiveness (Veronen and Kilpatrick, 1983). The methods suggested by the various people working in the field appears to be derived from clinical experience and subjective evaluation.

A small number of specific treatment approaches directed towards the problems of non-recent rape victims have been reported. Veronen and Kilpatrick (1983) reported on the successful treatment of six rape victims using a variety of techniques directed toward assisting victims to learn more appropriate coping skills. Blachard and Abel (1976) reported on the successful use of biofeedback training in assisting a subject to overcome a rape-induced psychophysiological cardiovascular disorder. Foman (1980) successfully employed Rational Emotive Therapy in treating rape victims. Cameron-Bandler (1978) reported on the successful treatment of a rape victim using Visual-Kinesthetric Disassociation.

Discussion

Generally the results obtained tended to support the subjective evaluations previously obtained and are consistent with those reported by Bandler (1985) and Cameron-Bandler (1985). As well, the subjective evaluations were consistent with the data obtained through the standard measures. In all cases except for one were a pre-treatment score was substantially elevated, that is elevated more than one standard elevation above the norm, by the end of treatment a substantial improvement had been noted. The exception was the overall subscale of the MFS II for Subject I which had not changed substantially over the courses of treatment. Conventional thinking and clinical observation as well as common sense might reason, however, that rape victims need more than two sessions to work through their post-traumatic stress. Just hypnotizing rape victims twice and at the second time suggesting to them a disassociation of the observing part of the personality from the experiencing part while remembering the rape, seems hardly enough to fully help the victim overcome the fear and emotional strain caused by the rape. The V-K Disassociation, nevertheless, coupled with hypnosis, seems to be an effective short term psychotherapy procedure and a promising avenue to explore in treating victims of rape. Fromm and Garner (1979) suggest that treatment can be shortened through the use of hypnosis: "Treatment time can indeed be shortened while sacrificing neither depth nor durability of the change in the patient" (p. 415).

It was originally thought by the researchers that both subjects would employ the V-K Disassociation treatment in similar ways. The results suggest, however, that each client used the V-K procedure in her own personal way. In the post treatment session, Subject I indicated that when she thought about the rape experience, it was as if she was seeing it on T.V. She reported feeling a greater distance from the event, remembering it in more objective manner. This subject is an example of utilization of the procedure in a predictable way.

Subject II utilized the procedure in a completely unpredictable manner. Although she had experienced two separate rape assaults, treatment had been directed only to the first of these. She seemed to need no specific treatment for the second and most recent assault. One explanation might suggest that her metaphorical application of the procedure was so complete as to allow her to deal with the second assault without further assistance. If this be true, two further possibilities can be considered.

On the one hand, the V-K Disassociation procedure, like many therapeutic interventions, is essentially metaphorical. As such, the treatment can operate on a number of levels simultaneously (Gordon, 1978). During session B, it is possible that psychological consequences of both assaults were simultaneously dealt with, although the first assault provided the conscious focus of the intervention.

On the other hand, Subject II's personal experience of learning to ski may indicate an extension of what had occurred in the treatment session. During that one hour of trance induction and the use of positive anchors of confidence and resourcefullness, the client gained the conviction that she could overcome her anxiety about rape, and master it; she then learned to ski quickly and found she could master something, and became even more convinced that she could master her fear of men.

While in treatment, Subject II had faced fear on the psychological level and had experienced positive success in working it through to integration. To be afraid means to feel alone and to remain constantly on guard, unable to trust oneself in whatever the context. Learning to ski may require facing fear on a physical level, to remain afraid, alone at the top of the hill looking down. The parallels are obvious; it can be argued that change in one sphere can facilitate change in other. As is the case with metaphores, their applicability lies not in content similarly but rather in construct equivalency (Gordon, 1978).

At the pre-treatment assessment period Subject II reported subtantially elevated scores on 16 of the depent measures. Three weeks after receiving session B, Subject II did not report any non-passive scales as substantially elevated. Subject I, on the other hand, reported 15 depent measures as substantially elevated at the pre-treatment assessment period and only 6 as being substantially

elevated upon completion of treatment. These results suggest that treatment was more 'through' or 'successful' for Subject II then for Subject I. These findings support an interpretation which suggests that Subject II utilized the treatment procedure beyond its specific confines.

Although no real checks on gender effects were employed, maleness may be cited as a factor in the treatment process of rape victims as the mere presence of a male may intensify the client's anxiety. Since the experience of hypnosis essentially involves learning how to become responsive to another person (Erickson & Rossi, 1981) and the fact that the "other person" in this situation was a male therapist working with a female rape victim who has fear, anxiety, and mistrust associated with men, she may in fact have generalized fear and distrust of men. The possibility existed that the female client will be resistant to change or experience an abresction.

In the case studies presented, rape victims lateness in seeking therapeutic help may be interpreted as an attempt to protect or even consolidate their ongoing present relationships with men, as for each of them their current relationship appeared to be of some importance. In the present design, one cannot avoid the strong compliance and demand characteristics in the three assessments carried out by the same male individual who was responsible also for the treatment.

If the client defies compliance-based interventions, one approach in dealing with the contradiction is to allow the client's unresolved issues to become exposed creating anxiety and strong resistance. In this situation, catharsis with awareness and responsibility will lead to meaningful change. Alternatively, paradox can be used as a clinical tool for dealing with the resistance and circumventing the power struggle. Paradox is based in the gestalt concept of the use of symptom as a mechanism for self-regulation (Minuchin & Fishman, 1981).

The Ericksonian and NLP approach of forming an alliance with the client's model of the world and using positive anchors, specifically avoids creating resistance and the need for therapeutic catharsis or paradoxical intervention. From a practical perspective, it appears that the metaphorical nature of the V-K Disassociation procedure allowed each client to employ it in a manner that would facilitate her own unique style of learning and recovery. It allowed the freedom to change and recover at individual rates and to address primary personal concerns without risking the creation of resistence. The three place V-K Disassociation technique seems to be an effective therapeutic tool that should be explored more thoroughly.

Implications

A number of observations can be made from this initial investigation to give direction to further research and practice. The primary problem that confronts a clinician attempting to assist a victim of rape is the selection of an appropriate treatment modality. Appropriate refers to treatment that has at least some empirical support as to its effectiveness. As well, appropriate is meant to refer to treatment which acknowledes individual differences and unique styles of learning and changing. This implies the need for a variety of treatment modalities from which clinicians may choose the most appropriate for their clients. The V-K Disassociation method of treatment fits with the Ericksonian model in having sufficient structure to provide a focus during therapy and enough flexibility to accommodate an individual's unique style of learning. Results suggest that the V-K Disassociation procedure is a useful intervention for assisting non-recent victims in overcoming blocks to natural functioning. Moreover, subjects reported the V-K Disassociation procedure to be gentle and non-obtrusive.

Use of the V-K Disassociation procedure has not been extensively researched. Based on this limited empirical support, any research or clinical implications arising from the use of this procedure must be interpreted in light of these limitations. Suggestions for further research employing the V-K Disassociation treatment procedure may be summarized as follows:

1. It would seem beneficial to investigate the efficiency of treatment employing a larger sample of twenty or more subjects. This would allow for a more thorough understanding of the specific treatment as opposed to idiosyncratic responses.
2. A follow-up component could be included so as to determine the long-term efficiency of treatment, say three to six months.
3. A female therapist could be employed to test the hypothesized male/female interaction effect.
4. The applicability of this procedure could be explored with male rape victims.
5. Phenomenological methods (Becker, 1986; Polkinghorne, 1986; Rogers, 1985; Wertz, 1984) could be employed in attempt to develop an in-depth understanding of chosen aspects of the V-K Disassociation experience.

Clinical implications for the use of this treatment procedure may include the following:

1. With certain clients, the use of trance-assisted V-K Disassociation can provide an effective means of helping clients overcome blocks to natural functioning.
2. A male therapist working with female victims of rape must be aware of the possible paradoxical nature of this course of treatment.
3. Short-term psychotherapy can be an effective means of aiding non-recent victims of rape.

REFERENCES

Albin, R.S. (1972) Review essay: Psychological studies of rape. Signs: Journal of Women in Culture and Society 3, 423-435.

Atkeson, B.M., Calhoun, K., Ellis, E. & Resick, P.(1982) Victims of Rape: Repeated Assessment of Depressive Symptoms. Journal of Consulting and Clinical Psychology 50 (1) 96-102.

Bandler, J. (1985) Using Your Brain for a Change. Moab, Utah: Real People Press.

Bandler, R, Grinder, J., and Sater, V. (1976) Changing with Families, Science and Behavior Books, Palo Alto.

Bandler, R., & Grinder, J. (1975) The Structure of Magic Volume I, Science and Behavior Books, Palo Alto

(1982) Reframing Neuro-Linguistic Programming and the Transformation of Meaning, Real People Press, Moab.

(1975) Patterns of the Hypnotic Techniques of Milton H. Erickson, M.D. Volume I, Meta Publications, Cupertino.

(1979) Frogs into Princess, Real People Press, Moab.

Becker, J. & Skinner, L. (1983) Assessment and Treatment of Rape-Related Sexual Dysfunctions. The Clinical Psychologist 36 (4) 102-105.

Becker, J., Skinner, L., Abel, G., & Tracy, E. (1982) Incidence and Types of Sexual Dysfunctions in Rape and Incest Victims. Journal of Sex and Marital Therapy 8 (1) 65-74.

Birier, R. (1981) Difficulties in Follow-Up of Rape Victims. American Journal Psychotherapy 35 (4) 534-541.

Blanchard, E. & Abel, G. (1976) An Experimental CAse Study of the Biofeedback Treatment of a Rape-Induced Psychophysiological Cardiovascular Disorder. Behavior Therapy 7 113-119.

Bloom, M. & Fischer, J. (1982). Evaluating Practices: Guidelines for The Accountable Professional, Prentice-Hall, New Jersey.

Burgess, A. & Holmstrom (1979) Rape: Sexual Disruption and Recovery. American Journal of Orthopsychatry 49 (4) 648-657.

(1981) Crisis Intervention Theory and Practice a Clinical Handbook, Prentice-Hall Inc., Englewood.
(1979) Rape: Crisis and Recovery, Prentice-Hall, Bowie Maryland.

(1976) Coping Behavior of the Rape Victim American Journal of Psychiatry 133 (4) 413-417.

(1974) Rape Trauma Syndrome American Journal of Psychiatry 131 (9) 981-986.

Buros, Oscar, K. (Ed.) (1978) The Eighth Mental Measurements Yearbook, The Gryphon Press, New Jersey.

Calhoun, K., Atkeson, B.M. & Ellis, E. (1982) A Longitudinal Examination of Fear Reactions in Victims of Rape. Journal of Counselling Psychology 29 (6) 655-661.

Cameron-Bandler, L. (1985) Solutions, San Rafael, Future Pace.

Dilts, R., Grinder, J., Bandler, R., Bandler, L. & Delozier, J. (1980) Neuro-Linguistic Programming Volume I, Meta Publication, Cupertino.

Edelstien, M.G. (1981) Trauma, Trance, and Transformation A Clinical Guide to Hypnotheraphy, Brunner/Mazel, New York.

Ellis, E., & Becker, J.(1967) An Assessment of Long-Term Reaction to Rape. Journal of Abnormal Psychology 90 263-266.

Erickson, M.H., Rossi, L. & Rossi, S. (1976) Hypnotic Realities the Induction of Clinical Hypnosis and Forms of Indirect Suggestion, Irvington, New York.

Erickson, M.H. & Rossi, L. (1981) Experiencing Hypnosis Therapeutic Approaches to Altered States, Irvington, New York.

Feldman-Summers, S.,Gordon, P. & Meagher, J. (1979) The Impact of Rape on Sexual Satisfaction. Journal of Abnormal Psychology 88 (1) 101-105.

Forman, B. (1980) Cognitive Modifiction of Obsessive Thinking in a Rape Victim: A Preliminary Study. Psychological Reports 47 819-822.

Fromm, E. & Shor, R. (1979) Hypnosis: Developments in Research and New Perspectives, Aldine Publishing Company, New York.

Frank, E. & Steward, D. (1983) Treating Depression in Victims of Rape. The Clinical Psychologist 36 (4) 95-98.

Fromm, E. (1965) "Hypnoanalysis: Theory and Two Case Excerpts". Psychotherapy: Theory, Research and Practice, No. 2, p. 129.

Fromm, E. & Gardner, G. (1979) "Ego Psychology and Hypnoanalysis". Bulletin of the Menninger Clinic, No. 43, p. 417.

Gordon, David (1978) Therapeutic Metaphors, Meta Publications, Cupertino.

Gortom, J. & Partridge, R. (1982) (Eds). Practice and Management of Psychiatric Emergency Care, St. Louis Mosby.

Grinder, J. & Bandler, R. (1977) Patterns of the Hypnotic Techniques of Milton H. Erickson, M.D., Volume II, Meta Publications, Cupertino.

Grinder, J. and Bandler, R. (1976) The Structure of Magic II, Sciences and Behavior Books, Palo Alto.

(1981) Trance-Formations Neuro-Linguistic Programming and the Structure of Hypnosis, Real People Press, Moab.

Hilberman, E. (1976) The Rape Victim, New York, Basic Books.

Horowitz, M.J. (1976) Stress Response Syndromes, New York, Aronson.

Janoff-Bulman, R. (1979) Characterologican Versus Behavioral Self-Blame: Inquiries Into Depression and Rape. Journal of Personality and Social Psychology 37 (10) 1798-1809.

Kilpatrick, D.G. & Veronen, B. (1983) Treatment for Rape-Related Problems: Crisis Intervention is Not Enough, W. Claiborn & G. Specter (Eds). Crisis Intervention, New York, Human Sciences Press.

Kilpatrick, D.G. (1983) (ed) Special Feature: Assessment and Treatment of Rape Victims. The Clinical Psychologist, Offical Publication of Division 12, American Psychological Association 36 (4) 88-105.

Kilpatrick, D.G. (1983) Rape Victims: Detection, Assessment and Treatment. The Clinical Psychologist 36 (4) 92-95.

Kilpatrick, D.G., & Veronen, L.J. (1979) The Aftermath of Rape: Recent Empirical Findings. American Journal of Orthopsychiatry 49 (4) 658-669.

Kilpatrick, D.G., Best, C.L. & Veronen, L.J. (1978) The Adolescent Rape Victim. In A.K.K. Kreutner & D.R. Hollingsworth (Eds). Adolescent Obstetrics and Gynecology (325-358), Chicago, Year Book Medical Publishers.

Lankton, S. (1980) Practical Magic, Meta Publications, Cupertino.

Lindemann, E. (1944) Symptomatology and Management of Acute Grief. American Journal of Psychiatry 101 (Sept) 141-148.

McCombie, S., Bassuk, E., Savitz, R. & Pell, S. (1976) Development of a Medical Center Rape Crisis Intervention Program. American Journal of Psychiatry 133 (4) 418-421.

Minuchin, S. & Fishman, H. (1981) Family Therapy Techniques, Cambridge, Massachusetts, Harvard University Press.

Mitchell, James, V. (Ed.) (1985) The Ninth Mental Measurements Yearbook, The University of Nebraska Press, Lincoln.

Norris, J. & Feldman-Summers, S. (1981) Factors Related to the Psychological Impacts of Rape on the Victim. Journal of Abnormal Psychology 90 (6) 562-567.

Notman, M. & Nadelson, C. (1976) The Rape Victim: Psychdynamic Considerations. American Journal of Psychiatry 133 (4) 408-412.

Perls, F., Hefferline, R. & Goodman, P. (1951) Gestalt Therapy: Excitement and Growth in the Human Personality, Dell Publishing, N.Y.

Polkinghorne, D. (1986) "Changing Conversations about Human Science." Saybrook Review, Vol. 6, No. 1, Spring.

Puryear, D.A. (1980) Helping People in Crisis, San Franciso, Jossy-Boss.

Resick, P., Calhoun, K., Alkerson, B. & Ellis, E. (1981) Social Adjustment in Victims of Sexual Assault. Journal of Consulting and Clinical Psychology 49 (5) 705-712.

Resick, P. & Jackson, J. (1976) The Psychological Treatment of Rape Victims: Past, Present, and Future. Paper presented at a symposium entitled "Perspectives on Rape" South-Eastern Psychological Association Convention, March 20, 1976.

Rogers, C. (1985) "Toward a More Human Science of the Person." Journal of Humanistic Psychology. 25(4), pp. 7-24.

Satir, V. (1972) Peoplemaking, Palo Alto, Science and Behavior Books.

Schultz, L.G. (1975) (ed) Rape Victimology, Springfield, Charles Thomas.

Shainess, N. (1976) Psychological Significance of Rape Some Aspects. New York State Journal of Medicine, Nov.

Smith, L. (1970) A Review of Crisis Intervention Theory. Social Casework, July.

Silvereman, D. (1977) First Do No More Harm: Female Rape Victims and the Male Counselor. American Journal of Orthopsychiatry 47 (1) 91-96.

Sutherland, S. & Scherl, D. (1970) Patterns of Response Among Victims of Rape. American Journal of Orthopsychiatry 40 (3) 503-511.

Udolf, R. (1981) Handbook of Hypnosis for Professionals, Van Nostrand Reinhold Comp., New York.

Walker, M. & Brodsky, S. (1976) (Eds) Sexual Assault: The Victim and The Rapist, Massachusetts, D.C. Heathe and Company.

Warner, C. (1980) Rape and Sexual Assault Management and Intervention London, Aspen.

Watzlawick, P. (1984) The Invented Reality, New York, W.W. Norton.

Watzlawick, P., Weaklong, J. & Fisch, R. (1974) Change Principles of Problem Formation and Problem Resolution, W.W. Norton & Comp., New York.

Werner, A. (1972) Rape: Interruption of the Therapeutic Process by External Stress. Psychotherapy: Theory, Research and Practice 9 (4) 349-351.

Wicks, R.J., Five, J. & Platt, J. (1978) (Eds) Crisis Intervention A Practical, Clinical Guide, New York, Slock.

Wilson, P. (1975) The Other Side of Rape, St. Lucia University of Queensland Press.

Vernon, L. & Best, C. (1983) Assessment and Treatment of Rape-Induced Fear and Anxiety. The Clinical Psychologist 36 (4) 99-101.

Veronon, L. & Kilpatrick, D.G. (1980) Self-Reported Fears of Rape Victims A Preliminary Investigation. Behavior Modification 4 (3) 383-396.

Veronen, L. & Kilpatrick, D.G. (1983) Stress Management for Rape Victims In D. Meichenbaum & M. Jaremko (Eds). Stress Reduction and Prevention 341-374, New York, Plenum.

Veronen, L. & Kilpatrick, D.G. (1983) Rape: A Precursor of Change. In E. Callahan & E. McCluskey (Eds). Life-Span Developmental Psychology: Nonnormative Life Events (pp 167-191), New York, Academic Press.

APPENDIX I

I would like to regard my patients as having a conscious mind and an unconscious or subconscious mind. I expect the two of them to be together in the same person, and I expect both of them to be in the office with me when I am talking to a person at the conscious level. I expect him to be listening to me at an unconscious level as well as consciously. Many of my patients find it helpful for me to encourage them to feel free to respond to whatever degree they wish.

Now can you sit straight with both feet together in front of you? Put your hands on your thighs, elbows comfortably against the side of your body, and learning something about a trance is essentially learning about the way you experience. You don't know just how the changes take place in your feeling from the conscious state to the unconscious state. Now, the unconscious state of mind, the facts that the mind....you know how to tie shoe strings, but if you are asked to specify the movements in order, you don't know them. You don't know what the body orientation is in the matter of developing a trance. I have to watch for different orientations in your body response. Now there is no hurry on your part. There is no rush, you simply wait. You let me do the talking. In time I'll ask you certain things, and as it becomes a natural feeling with you, you will answer, but in your own way.

Now, I'm going to call your attention to your hands. There are memories associated with your hands, with your arms, with your elbows. Just what all of those memories are would be impossible to state. Now I'm going to make a statement to you about your behavior. When --- the movement was that of a strictly conscious mental set. The unconscious moves the hand in a different way. I'll call your attention to your hands again. I want you to wait until one of them begins to move towards your face, very slowly. Which one? We'll have to find out. There will be a choice. Maybe your right hand, maybe your left. Or it may be the dominant hand. You really don't know. You just wait and let your unconscious mind make the choice, and slowly you will become aware that the hand begins to lighten. It may feel somewhat different and you sense a tendency in the elbows, a tendency to behavior. You may or may not become aware of that. It is sufficient that only your unconscious mind becomes aware and be willing to show an increasing dominant choice.

Certain things have been occurring of which you are aware. Your blood pressure has altered; that you are unaware. Your blood pressure has altered; that is a matter of course in all subjects. Your hand is responding just a bit more and soon your elbow will come into play. You may be aware your breathing rate has altered and the patterns of breathing. Now the thing is your heart rate has changed. I know this by virtue of the fact that I can observe your pulse in your neck. Sometimes I can see it in the temples, but the

important thing is for you to discover that the hand lifting slowly upward, there's enough dominance in one hand for you to become aware of it. You will be patient because the unconscious is learning for the first time how to take over intentionally, responsive to another person.

Your body has been responding in many ways on an unconscious level without your knowledge. When you meet a person for the first time, there are certain muscles that contract. There are certain muscles that relax and you respond differently to different people.

Now your hand is lifting away from your thigh, lifting up and it will become higher and higher. Now think of it coming up, coming up, and perhaps you can feel it move toward some object just above your head. A little bit higher. Now the elbow will get ready and the wrist will lift. Now all of your learning has a certain carefulness, a slowness, a precisionness inculcated in your pattern of learning. This is one bit of learning which you do not need to learn to be responsible, and there is no rigid pattern for it to follow. It is purely a spontaneous sort of thing. Spontaneity of muscle effort on your part has been trained into one position, and care, and that's one thing that is going to have to be altered.

And now you are making still more progress, showing your own particular pattern of hand levitation, and you are showing your elbow movements are not those of a another person. They are your patterns of elbow movement. That's fine, because your arm has risen, and you begin to wonder when your hand will get all the way

up. Where you can wonder which will be first to loosen, to lose contact with your thighs, It is losing contact here, there. I don't even know if you know which hand it is but that is not important. Your pattern of learning may be to include the exclusion of your own awareness. Exclusion of your awareness is not wrong, it's not necessary. You've been trained by experience to be very aware as if awareness in this situation were important, but you are actually accomplishing something. It's going up more and more. You've already accomplished enough to achieve awareness. It is a necessary part of our learning. To me it is important that you learn in any way that you can, and I'm fully aware that your part is to learn a pattern of responses, not common to me. It's lifting higher and higher. Your unconscious mind has moved the hand. It's already made the elbow move, and it's altering contract with your leg, and now sooner or later they'll be pushed by your unconscious mind is going to pull or push your hand upward and you are actually increasing your learning. In a way your hand had a double purpose, which is very nice.

You have a tendency to learning more than you are aware of. You can be aware of some and be unaware of some. Lifting higher and higher, more rapidly, and now it is lifting up very, very smooth. Your head is bowing down towards it very slowly. Bowing down toward your hand as your head bows, your hand will lift easily, bowing down, very slowly. And the hand lifting to meet the face, bowing down, slowly, down, down, up, down, up, down, down, up, down, up,

your head is getting lower. Your fingers are about ready to lose contact. More of that slight jerk and some of your fingers will be off lifting, lifting, when your hand is off you will have learned a great deal, only you won't know what it is your have learned. But it will be a sizeable amount with which you can work, if you want to know something of how to, that's right, a nice jerk, soon there will be another. Your head is getting a bit lower, hand lifting, that's right, another movement. Wonder why there would be jerky movements. There are always jerky movements. That's part of physical learning. Learning smooth movements and slowness is not anything to be distressed by. That's right, lifting all of its own. Up it comes. Now it extends to your forearm and elbows, and the tension will increase in the elbow and it isn't necessary for you to speak to me. You've heard what I have had to say. Your experience of learning to retain the spoken word and you, you can repeat this on and on through your mind, and making your response fit your memories as my words flow through your memory. And that way you're going to enhance your learning. That's right. You've already learned so much. You may not know you have yet learned anything about hypnosis. You may not feel you have learned anything. Your unconscious mind may know what it has learned. So I'm going to pose a situation and in the situation we will both wait for the answer. If your unconscious mind knows that you have learned something, your head will slowly nod yes. If your

unconscious mind thinks no, it will slowly shake no. Now we will wait for the answer. Has your unconscious learned something about hypnotic response? Now a positive answer is a nod of the head. A negative answer is a shake of the head. So far what you have attained has been a slight nod and a slight shaking, meaning I don't know.

Now the unconscious mind does have a lot of repressed knowing. That's why we call it the unconscious. Now slowly move your head down, down until your chin touches your shirt. Down still further, and keep on going till your chin touches your shirt. It seems so long and far away, the shirt does, and you can get your chin on it eventually by sensing your hand, or your forearms, or your neck, or your thighs, or your calves, by paying attention to first one part, and then another part of your body. And last of all, feel the comfort in your head, and feel the sense of being rested. Now when learning hypnosis, it it not important to know what you have learned. What is important is the acquisition of the knowledge and having it ready to utilize when the proper stimulus comes.

Now I would like you to awaken, so very slowly, come awake. Not all over. I want you to learn to enjoy sensing what trance feelings are in the various parts of your body. You many not get all of the feelings in all of the parts all at once. It is a learning process. I would like to have you, as soon as you are ready in your own way to speak and say I am awake, when you feel you are awakened.

APPENDIX II

The SCL-90-R

The Nineth Mental Measurements Yearbook (Mitchell, 1985) states that the SCL-90R ...test retest (1-week apart) correlation coefficients range from .78 (Hostility) to .90 (Phobic Anxiety) in a psychiatric population (p. 1327). As well, the review article stated that "Another use to which the test has been put is to evaluate the effects of the psychological stress associated with such things as death, disaster, rape, pain, chronic tension headache, cancer and anorexia nervosa. Each of these stressors has been associated with some symptomatoloty as evaluated by the SCL-90R" (p. 1327). Finally the article concludes that "...the SCL-90R is an interesting and reliable self-administered psychiatric symptom check list which can be very useful in research studies" (p. 1329). Suggesting that the SCL-90R is an appropriate instrument for use in this study.

The SCL-90-R is a 90-item self-report symptom inventory. It is designed primarily to reflect the psychological symptom patterns of psychiatric and medical patients. The SCL-90-R is a R (revised) form based on earlier clinical experiences and psychometric analysis (Derogatis 1983).

Each item of the "90" is rated on a five-point scale of distress (0-4), ranging from "not-at-all" at one pole to "extremely" at the other. The scoring and interpretation of the "90" is based on nine primary symptom dimensions and three global indices of distress (Derogatis, 1983). The nine subscales and three global scales are labeled:

I. Somatization
II. Obsessive-Compulsive
III. Interpersonal Sensitivity
IV. Depression
V. Anxiety
VI. Hostility
VII. Phobic Anxiety
VIII. Paranoid Ideation
IX. Psychoticism

Global Severity Index (GSI)
Positive Symptom Distress Index (PSDI)
Positive Symptom Total (PST)

Derogatis (1983) states that the three global scales reflect distinct aspects of psychological disorder and were included to provide greater flexibility in overall assessment (Derogotis, 1983).

Test Administration and Instructions

Under normal conditions Derogotis (1983) found that the test was completed in 12 to 15 minutes by most respondents.

The instructions given subjects in completing the assessment package were the following:

> In order to obtain some indication of how you are feeling I would like you to complete four questionnaires. As each questionnaire is different please ensure that you read the directions carefully and follow them.

The specific instructions accompanying the "90" test form were:

> Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please fill in one of the numbered circles to the right that best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST WEEK INCLUDING TODAY. Mark only one numbered circle for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example below before beginning, and if you have any questions please ask the technician. (Derogotis 1983)

Definition and Descriptions of the SCL-90-R Subscales

Somatization

Distress arising from perceptions of bodily disfunction are reflected in the Somatization dimension. Included in this scale are complaints focused on cardiovascular, gastro-intestinal, respiratory and other symptoms with strong antonomic mediation. As well, headaches, pain and discomfort of the gross muscular and somatic equivalents of anxiety are included. These signs and symptoms, though reflective of true physical problems, are reported to correlate strongly with disorders of a functional etiology (Derogatis, 1983).

Obsessive-Compulsive

The obsessive-compulsive dimension reflects "thoughts, impulses and actions that are experienced as unremitting and irrestible by the individual but are of an ego-alien or unwanted nature." (Derogatis, 1983, p. 7.)

Interpersonal Sensitivity

This dimension focuses on "feelings of personal inadequacy and inferiority, particularly in comparison with others." (Derogatis, 1983, p. 7.) Characteristic manifestations of this syndrome are self-depreciation, feelings of uneasiness and marked discomfort during interpersonal interactions.

Depression

The items included within this subscale were selected so as to reflect a broad range of the manifestations of clinical depression. Included in the depression subscale are symptoms of dysphoric mood and affect as are signs of "withdrawal of life interest, lack of motivation, and loss of vital energy. In addition, feelings of hopelessness, thoughts of suicide, and other cognitive and somatic correlates of depression are included." (Derogatis, 1983, p. 8.)

Anxiety

The anxiety subscale is composed of a set of symptoms that are clinically associated with high levels of manifest anxiety (Derogatis, 1983). Panic attacks and feelings of terror along with nervousness, tension and trembling are included. Thoughts involving feelings of apprehension and dread, and some somatic correlates of anxiety are included as well.

Hostility

"The Hostility dimension reflects thoughts, feelings or actions that are characteristics of the negative affect state of anger. The selection of items includes all three modes of manifestation and reflects qualities such as agression, irritability, rage and resentment." (Derogatis, 1983, p. 9.)

Phobic Anxiety

Derogatis (1983) defines phobic anxiety as a "persistent fear response to a specific person, place, object, or situation which is characterized as being irrational and disproportionate to the stimulus, and which leads to avoidance or escape behavior" (p. 9). This subscale reflects the more disruptive manifestations of phobic behavior and is in very close agreement with the definition of "agoraphobia" (Derogatis, 1983).

Paranoid Ideation

This subscale was designed to reflect disordered mode of thinking. "The cardinal characteristics of projective thought, hostility, suspiciousness, grandiosity, centrality, fear of loss of autonomy, and delusions are viewed as primary reflections of this disorder, and item selection was oriented toward representing this conceptualization." (Derogatis, 1983, p. 10.)

Psychoticism

This subscale was designed to represent the construct as a continuum (Derogatis, 1983). The scale thus ranges from mild interpersonal alienation to psychosis. Items included were those indicative of the isolated, withdrawn schizoid lifestyle and first-order symptoms of schizophrenia, such as hallucinations and thought-broadcasting.

The Global Indices of Distress

The SCL-90-R provides three global measures of distress: Global Severity Index (GSI); the Positive Symptom Distress Index (PSDI); and the Positive Symptom Total (PST). The GSI is a single summary measure of the person's present level of distress. (Dergatis, 1983.) The PSDI score is an indicy of intensity corrected for number of symptoms. The PST is simply a count of the number of symptoms the person has indicated as experiencing.

The Veronen-Kilpatrick Modified Fear Survey (MFS-II)

The MFS-II (Veronen & Kilpatrick, 1980) is a 120-item inventory of potentially fear-producing items and situations. Each item is rated on a five-point scale of distress (1 to 5) ranging from "not-at-all" at one pole to "very much" at the other. The scoring and intepretation of the MFS-II is based on seven subscales and one global score. The seven subscales are:

I. Animal Fears - A
II. Tissue Damage - T
III. Classical Fears - C
IV. Social Fears - S
V. Miscellaneous Fears - M
VI. Fear of Failure - F
VII. Rape Related Fears - R

The MFS-III is a modified form of the original Walpe & Long (1964) Fear Survey Schedule with the addition of 42 rape-related items. Each of the subscales contains items which reflect it's name. No review of the MFS-III could be found and its inclusion was based on the work of Veronen & Kilpatrick (1980).

Profile of Mood States (POMS)

A review article in the Eighth Mental Measurements Yearbook (Biros) indicates that the POMS Reliability appears to be acceptably high ....Test-retest corelations range from .65 to .74 with median .69. This is a considerable difference, but it is concordant with the purpose of measuring transient, fluctuation affective states (p. 1016). .....The POMS scales have considerable face validity. There is considerable redundancy in these scales, and it is not surprising that internal consistency is high (.1017). ....The forte of instruments such as POMS is in the area of treatment ecaluation, usually psycho-therapy and/or medication (p. 1018). ....While validity of the test is apparently well established, some further studies of realiability are needed (p. 1019). The POMS thus seems to be an appropriate instrument for this study.

The profile of Mood Sates (McNair et. al., 1981) is a 65-item questionnaire designed to measure six identifiable mood or affective states. Each item of the POMS is rated on a four-point scale (1-4) of intensity ranging from "not-at-all" at one pole to "extremely" at the other. The scoring and interpretation of the POMS is based on six subscales:

I. Tension-Anxiety
II. Depression-Dejection
III. Anger-Hostility
IV. Vigor-Activity
V. Fatigue-Inertia
VI. Confusion-Bewilderment

Test Administration and Instructions

Under normal conditions McNair et. al. (1981) found that most respondents could complete the questionnaire in three to five minutes. The specific instructions accompanying the POMS were:

> Below is a list of words that describe feelings people have. Please read each one carefully. Then fill in ONE space under the answer to the right which best describes HOW YOU HAVE BEEN FEELING DURING THE PAST WEEK INCLUDING TODAY (McNair et. al 1981).

Definitions and Descriptions of the POMS Subscales

Tension-Anxiety

The tension anxiety scale is defined by items which are descriptive of heightened musculoskeletal tension. Included are items which are reflective of somatic tension that may not be overly observable (tense, on edge) as well as those that may be more

readily observable (shakey, restless). Also included are items which refer to vague, diffused anxiety (anxious, uneasy). (McNair et. al., 1981.)

Depression-Dejection

The Depression-Dejection scale is defined as items which "represent a mood of depression accompanied by a sense of personal inadequacy. It is best defined by scales indicating feelings of personal worthlessness, futility regarding the struggle to adjust, a sense of emotional isolation from others, sadness and guilt." (McNair et. al., 1981, p. 7.)

Anger-Hostility

The Anger-Hostility scale represents a mood of anger and antipathy towards others. Items included in this subscale were chosen to reflect intense, overt anger or the milder feelings of hostility.

Vigor-Activity

The items in the Vigor-Activity scale were chosen to reflect a mood of vigorousness, exuberance and high energy. This scale is negatively related to the other POMS scales and probably represents a positive affect. (McNair et. al, 1981.)

Fatigue-Inertia

This scale is reflective of an affective state characterized by weariness, inertia and low energy level. Though negatively related to the Vigor-Activity scale the Fatigue-Inertia scale has been shown to be an independent factor and not merely an opposite of a bipolar factor. (McNair et. al., 1981.)

Confusion-Bewilderment

The Confusion-Bewilderment scale is characterized by a mood state of "bewilderment" and "muddleheadedness". McNair et. al. (1981) report that there is uncertainty as to whether the scale represents cognitive inefficiency, a mood state or both.

State-Trait Anxiety Inventory (STAI)

A review in the Eighth Mental Measurements Yearbook (Buros 1978) stated that ....the STAI is an excellent choice for the clinical psychologist or personality researcher looking for an easy-to-administer, easy-to-score, reliable, and valid index of either individual differences in proneness to anxiety or individual differences in transitory experience of anxiety (p. 1096). The review article supports the inclusion of the STAI in this study.

The STAI (Spielberger, 1983) is designed to assess a respondent's subjective experienes of anxiety along two dimensions: trait anxiety (T-Anxiety) and state anxiety (S-Anxiety). Trait Anxiety refers to relatively stable differenes between people to perceive situtions as stressful and to respond to such situations with increased state anxiety. "T-Anxiety may also reflect

individual differences in the frequency and intensity with which anxiety states have been manifsted in the past, and in the probability that S-Anxiety will be experienced in the future." (Spielberger, 1983, p. 1.) State Anxiety refers to the amount of anxiety experienced by the person. It varies over time and situations as a function of the amount of stress that impinges upon the person. S-Anxiety is thus conceptualized as a mood state while T-Anxiety is held to be a stable personality trait.

The STAI is a 40-item questionnaire. Each item of the STAI is rated on a four-point scale of distress (1 - 4), ranging from "not-at-all" at one pole to "very-much-so" at the other. The scoring and interpretation of the STAI is based on two scales: S-Anxiety and T-Anxiety.

The S-Anxiety scale is administered as recommended first and is accompanied by the following instructions:

> A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you <u>generally</u> feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

The T-Anxiety scale is administered next and is accompanied with the following instructions:

> A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel <u>right</u> now, that is, <u>at this moment</u>. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.