Personality and Hypnosis as Variables in the Treatment of Sexual Abuse

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A Thesis submitted to the Faculty of Arts
in Partial Fulfilment of the Requirements for
the Degree of Master of Arts

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Thunder Bay, Ontario

December, 1994

ISBN 0-612-09221-6

Canada

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Abstract

The intent of this study was to investigate the use of hypnosis in the treatment of sexual abuse, searching for characteristics of personality common to both the practitioner who uses hypnosis to treat survivors of sexual abuse, and the sexual abuse survivor who benefits from hypnotherapy. One thousand health practitioners in the province of Ontario, comprised of physicians, psychologists and crisis centre workers, as well as approximately 500 sexual abuse survivors at various stages of treatment, were surveyed and asked to complete a brief questionnaire regarding attitudes and experiences, together with the Myers-Briggs Type Indicator. Survey packages were distributed in both local and remote crisis centres, as well as being mailed to practitioners, and distributed to survivors who were undergoing and/or who had been treated using hypnosis. It was found that the intuitive (N) preference of the Myers-Briggs typology was significant in predicting receptivity towards the use of hypnosis, while the hypothesized perceptive (P) preference bore a

more complex relationship. The presence of a history of abuse, and subjective evaluation of "survivor" status appeared to influence receptivity independent of Myers-Briggs type. Factors related to dreaming, gender, handedness and strength of Myers-Briggs preference were found to bear a relationship to subjects' inclusion in practitioner or non-practitioner categories. Plausible interpretations are offered, and suggestions proposed regarding possible directions for further study.

DEDICATION

Without a doubt, the dedication of this thesis belongs to my parents. In their own very unique and complimentary ways, they have both had profound influence upon me. Both exemplified a rigorous work ethic, instilling in me at an early age a strong desire for quality achievement. Throughout my life, my Mom Maria has unfailingly been my shelter from the storm. Her personal strength and fortitude have become my backbone. Her unfaltering belief in me, her uncompromised support and her friendship have been hallmarks of our relationship. Since my Dad's passing three years ago, I have come to better understand and appreciate the significance of our relationship. As a regular part of daily living, my Dad Michael provided my truest and most meaningful lessons in respect. At the same time, he unpretentiously taught me his second language - the language of feelings. I consider myself truly blessed to have been the benefactor of this wealth, and for such a significant part of my life. Their caring is truly the antithesis of what lies at the heart of my thesis.

ACKNOWLEDGEMENTS

The completion of a Master's thesis normally reflects the contributions and support of a number of individuals. This thesis certainly warrants such recognition, and as such I would like to extend my grateful appreciation to the following individuals:

Eric Maier, for his thoughtfulness in providing the "perfect" work environment, his assistance in labelling surveys, his thoroughness in proof-reading material, and especially for his infinite, good-humoured patience in living through months of congestion;

Maria Lylyk, for her enthusiasm and perfectionism, evident in the countless hours spent painstakingly checking survey responses and coding results;

Robin Odell, for her thoroughly enjoyable assistance in the typing of all mailing labels;

Walter Martin and staff, for their kind provision of copy and printer equipment, and for their thoughtful input regarding the survey questionnaire;

Patricia Derraugh, for her co-operative attitude,

time and assistance in providing hypnosis contacts affiliated with the Ontario Society of Clinical Hypnosis;

Dr. Eileen Alexander, for her inspiration, encouragement, and insightful information regarding the treatment of sexual abuse via hypnosis in clinical practice;

Dr. William Melnyk, for so willingly sharing his experience, for his patience and understanding, and especially for his belief in me and support in "swimming upstream";

Dr. Alicia Ruiperez, for sharing her valuable contacts, her careful attention to details, and her friendly guidance;

Dr. Robert Schwarz, for his thoughtful, provocative input, and for the diplomatic style in which it was offered; and last but not least,

Dr. Shirley Winlaw, for her time, keen interest and thorough suggestions, all proffered in a most charitable manner that I found impressive and appreciated greatly.

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"If you have twenty clients and a good percentage of them are women, you're going to be working with some survivors - whether you're aware of it or not. I don't see how you can be a therapist today, in this country, and not be in the field. I didn't consciously choose to work with survivors."

Patricia Pavlat, therapist

The above statements, as quoted by Bass and Davis (1992, p. 345), carry significant import, eluding to a face of mankind that has long been masked. Abuse, in all of its disheartening forms, finds its way into the lives of an astonishing number of individuals, both in childhood and in adulthood. The majority of these individuals are women and children, although this is by no means exclusively so. However, for the females involved the abuse appears self-perpetuating. An extensive review of the impact of child sexual abuse in the research literature conducted by Browne and Finkelhor (1986), points to the apparent vulnerability of women who have been sexually abused as children to be revictimized (raped) later in life. Also in addition to rape, victims of child sexual abuse appear more likely to be abused later by husbands or other adult partners.

Many practitioners acknowledge a high incidence of abuse-related problems with their clients. In relation to this study, sources in the areas of medical general practice (E. Alexander, personal communication, 1993), sex therapy (E. Sommers, personal communication, 1992), and institutional psychiatry (Craine et al., 1988) reported that 25%, 50+% and 51% respectively of their clientele presented with a history of sexual abuse. These findings augment an estimate made by Russell (1986, p. 60-61), where the prevalence of sexual abuse in women, even in non-clinical populations, was felt to lie somewhere between 19 and 31%. As concluded by Kiser et al. (1991, p. 782) in their study of childhood sexual abuse, with over 50% of patient population experiencing some type of child abuse and with over 50% of those patients developing clinical symptoms specifically related to abuse, the value of studying the effects of child physical and sexual abuse in clinical populations is clearly understated.

Many researchers have suggested a relationship between physical and/or sexual abuse and post-traumatic stress disorder (PTSD) (Kiser et al., 1991; Terr, 1991;

Herman et al., 1989; McCormack et al., 1988), with a number of studies substantiating the link between childhood sexual abuse and PTSD (Lindberg & Distad, 1985; Donaldson & Gardner, 1985; Kiser et al., 1988; McLeer et al., 1988; O'Neill & Gupta, 1991). The essential feature of PTSD, as stated in DSM-III-R by the American Psychiatric Association (1987), is the development of characteristic symptoms following the experience of a traumatic event that is outside the range of normal human experience. Characteristic symptoms involve:

(1) reexperiencing the traumatic event, as intrusive recollections, nightmares or flashbacks

(2) numbing of responsiveness to the external world

(3) other autonomic, dysphoric, or cognitive reactions such as hyperalertness, sleep disturbances, survival guilt, memory impairment, avoidance of reminders, and intensification of symptoms when exposed to reminders of the event.

In support of the positive relationship between sexual abuse and PTSD, a study by O'Neill and Gupta (1991), found that 73.1% of their sample of sexually abused women (who had been referred for psychiatric examination) fulfilled the above criteria for post-traumatic stress disorder. Results from a number of

studies of rape (Burge, 1988; Steketee and Foa, 1987), affirmed the connection between victimization by rape and PTSD symptomatology. Clinical studies of PTSD in children (Lindberg and Distad, 1985; Terr, 1983) have been found to consistently list the following symptoms:

development of trauma-related/mundane fears,
sleep disturbances,
nightmares,
regressive bedwetting,
eating disturbances,
guilt,
acting out or withdrawal behaviour,
depressive behaviours,
mistrust and irritability.

Parallels to the DSM-III-R PTSD diagnostic criteria mentioned earlier can be readily drawn from these symptoms.

Terr (1991) further suggests that there are four characteristics related to childhood trauma that appear to last for long periods of life, no matter what diagnosis a patient eventually receives. These are visualized or otherwise repeatedly perceived memories of the traumatic event, repetitive behaviours, trauma-specific fears, and changed attitudes about people, life, and the future. Terr further categorizes childhood trauma into two types as follows:

- Type I trauma (single traumatic episode) includes full, detailed memories, omens and misperceptions,
- Type II trauma (long-standing or repeated trauma) includes denial and numbing, self-hypnosis and dissociation, and rage.

It is suggested by Terr that conceptually there are actually two types of post-traumatic stress disorder, based on the above categorizations. Recent empirical evidence by Kiser et al. (1991) tends to support this hypothesis. These researchers found that children and adolescents reacting to single event abuse appeared to display more behaviour disorders, whereas victims of ongoing abuse appeared significantly more disturbed, with symptoms ranging from depression to psychosis.

A diagnosis of PTSD is not an inevitable sequela to abuse however. Several studies point to the interaction of mediating factors, influencing whether a particular abused individual will exhibit symptoms of PTSD or not, and to what degree. Factors such as one's perception of control over the traumatic event and degree of intrafamilial social support (McCormack et al., 1988), the age and developmental stage of the

child (Browne and Finkelhor, 1986), specific characteristics of the victim and the incident (Malmquist, 1986), the nature of the relationship between the child and the perpetrator(s) as well as their genders (Schultz and Jones, 1983), the frequency and duration of abuse (Tsai et al., 1979), and the use of force and/or violence (Elwell, 1979; Schultz and Jones, 1983) all appear to modulate the impact of trauma/abuse.

Within this context of examining the effects of sexual abuse, researchers have further identified symptomatology differences between clinical and non-clinical sexual abuse survivors. A study done on non-clinical samples show women who have been sexually abused to have higher levels of dissociation, somatization, anxiety and depression than non-abused women (Briere and Runtz, 1988). Comparisons of rape victims and non-victims have consistently shown that the former had higher levels of fear and anxiety (Kilpatrick et al., 1979a, 1979b, 1981; Ellis et al., 1981; Calhoun et al., 1982). In addition, rape victims have also reported a variety of other symptoms

following assault, including fatigue (Ellis, Atkeson and Calhoun, 1981); hostility (Kilpatrick, Resick and Veronen, 1981; Selkin, 1978); sleep disturbance including nightmares and insomnia (Ellis, Atkeson and Calhoun, 1981; Nadelson et al., 1982); poor concentration and intrusive thoughts (Nadelson et al., 1982); poor self-esteem (Veronen and Kilpatrick, 1980); and obsessive-compulsive symptoms (Ellis, Atkeson and Calhoun, 1981). To reiterate the thoughts of Steketee and Foa (1987), the overall picture emerging from the literature on the aftermath of rape indicates that virtually all of the symptoms which define post-traumatic stress disorder appear in rape victims.

Given then that there can be many twists and turns on the path that leads an abuse survivor to seek the assistance of a practitioner, it certainly behooves the practitioner to be well-versed in the treatment of post-traumatic stress. In this regard, there are many approaches a clinician may opt for which, through association, have applicability in the treatment of sexual abuse as well. Imagery (Grigsby, 1987; Keane & Kaloupek, 1982; Fairbank & Keane, 1982; Keane et al.,

1985; McCaffrey & Fairbank, 1985), hypnotherapy (Dolan, 1989; Brom et al., 1989; Spiegel, 1988; Mutter, 1986; Brende, 1985; Brende & Benedict, 1980; Ebert, 1988; Gilligan & Kennedy, 1989; McMahon, 1986; Silver & Kelly, 1985), trauma desensitization (Brom et al., 1989; Kipper, 1977; Schilder, 1980), psychodynamic therapy (Brom et al., 1989; Horowitz, 1973, 1986), behaviour modification (Fairbank et al., 1981; Ayalon, 1983; Veronen & Kilpatrick, 1983) and medication (Burstein, 1986; Davidson et al., 1990, 1991; Famularo et al., 1988; Frank et al., 1988; Schwartz, 1990) represent a number of these approaches which are often combined according to a client's needs and abilities. However, as stated by Schwarz and Prout (1991), there are five strategies that can be seen in virtually all of the different PTSD treatment approaches. These are:

1) supporting adaptive coping skills
2) normalizing the abnormal
3) decreasing avoidance
4) altering attribution of meaning
5) facilitating integration of the self.

The above can be summed up in the single concept of

empowerment - assisting the client to gain control of an experience and associated feelings that have, for the most part, remained out of the client's perception of control.

One of the therapeutic methods mentioned above that has been found to be particularly empowering by many practitioners in the treatment of PTSD in general, and sexual abuse in particular, is hypnosis (E. Alexander, personal communication, 1993; A. Ruiperez, personal communication, 1993; Spiegel, 1989). As stated by Evans (1991), hypnosis has been found to be especially useful in allowing the patient to regress to, or recall, the traumatic experience and abreact (or re-live) the emotionally charged content of the event. Then, it has further utility as a means of helping patients reintegrate the psychic split caused by the trauma and to redevelop a sense of mastery (or empowerment) over their lives.

According to Rossi (1990, pp.450-451), this access and subsequent integration is possible because the classical phenomena of hypnosis, post-traumatic stress disorders, multiple personality, neurosis,

psychosomatic symptoms and mood disorders can all be understood as manifestations of state-dependent behavioural symptoms. In other words, the physiological state of the brain at all times determines the expression of memory, learning and behaviour. Under stress, certain patterns of memory, learning and behavioural symptomatology are learned and encoded by the release of stress hormones and information substances (neuropeptides such as hormones and growth factors) throughout the entire mind-body. Remove the stress, the information substances disappear and the individual apparently recovers and seems symptom-free. Re-introduce stress to varying degrees, and the mind-body responds by releasing the information substances that revoke the corresponding degree of symptomatology. Therefore, if the traumatic event and all associated symptomatology is accessed and the patient can subsequently re-frame the event, viewing him/herself in more of a position of control, the information substances change accordingly, altering the traumatic behavioural reactions in turn.

Interestingly, the few studies that have

investigated the relationship between traumatic stress and hypnotizability found consistent support for significantly enhanced hypnotic potential in clients presenting with post-traumatic stress (Hilgard, 1970; Spiegel et al., 1988; Stutman & Bliss, 1985). More recently, research has suggested that physically and sexually abused subjects were more distinguishable by their proneness to fantasy than by their measure of hypnotizability per se (using both objective and subjective hypnotizability measures) (Rhue et al., 1990). However, it is important to recognize that this fantasy-proneness, which reflects an ability to dissociate from reality and operate mentally on more than one level at a time, is fundamental to the hypnotic state (Hilgard, 1986). Furthermore, it has repeatedly been found to be associated with hypnotic susceptibility (Council et al., 1986; Lynn & Rhue, 1988; Rhue & Lynn, 1987). Paralleling this are the related findings that dissociative phenomena such as fantasy-proneness appear to be mobilized by trauma (Noyes & Kletti, 1977; Noyes & Slymen, 1978; Wilkinson, 1983; Siegel, 1984; Solomon et al., 1989), and are also

intrinsic to the symptomatology of PTSD (Spiegel & Cardena, 1990); Spiegel, 1989).

A popular clinical interpretation of hypnosis describes it as a state of intensely focused concentration with a relative suspension of peripheral awareness (Spiegel & Spiegel, 1978). Absorption, dissociation and suggestibility are the three major components considered to characterize hypnosis. The following describes an interesting parallel between these components of the hypnotic state and the symptoms of PTSD (American Psychiatric Association, 1987). As outlined by Spiegel (1989), PTSD symptoms are intensely absorbing, and when they occur tend to soak up all of an individual's attentional resources. They result in a more subtle and pervasive reduction in responsiveness to other stimuli and events in the individual's life, and such individuals are extremely sensitive to certain environmental cues symbolically related to the trauma. For victims of sexual assault, this dysfunction takes the form of interpersonal difficulties, especially in rebuilding a normal sexual adjustment.

Hypnosis crosses three major disciplines, finding

utility in medicine, dentistry and psychology. Within Ontario alone, approximately 400 professionals (comprised of physicians, psychologists and dentists) are registered as having trained with the Ontario Society of Clinical Hypnosis. In the United States, the number of professionals utilizing hypnosis (registered and otherwise) has been estimated by the American Society of Clinical Hypnosis to be in the neighbourhood of 20,000. Yet, as effective as hypnosis appears to be for certain practitioners, there are many more who have not included it in their treatment repertoires, and may have no desire to do so. Likewise, there are clients who have found significant benefit from this therapeutic approach, while there are others who are simply not interested. Are there any systematic differences then amongst practitioners, predisposing some and not others to opt for hypnosis as a therapeutic treatment for sexual abuse? And, are there these same, or other differences existing amongst clients which if known, could help to determine in a relatively quick and easy manner who could benefit the most from the use of hypnosis in dealing with their

trauma?

A review of earlier studies investigating personality and hypnotizability revealed very little relationship between the two (Barber, 1964). More recently, studies have found varying degrees of relationships. One of these, investigating need for achievement and autonomy, self-monitoring and locus of control found only a clouded relationship to exist for locus of control (Kihlstrom et al., 1980; Austrin & Pereira, 1978), linking externally-controlled females with higher hypnotizability. Another, by Schwartz and Burdsal (1977) found general intelligence and a combination of warm-heartedness, shrewdness and obsessiveness to have a relationship to hypnotizability. Method of hypnotic induction was found to be related to personality by Moss and Magaro (1989). Results from their study revealed the hysteric personality to be significantly more hypnotizable than other personality types in a group induction context, whereas the compulsive personality was found significantly more hypnotizable in a self-hypnosis induction context.

Present Study

The intent of this study was to steer away from assessing hypnotizability as such, and to instead investigate the relationship between personality and hypnosis from a different angle, searching for personality variables that distinguish individuals receptive to the clinical use of hypnosis for treating sexual abuse, from both the practitioner and client perspective. Such findings may have potential clinical relevance and applicability for clinicians in the treatment of sexual abuse in particular, and post-traumatic stress in general.

The personality measure of choice is the Myers-Briggs Type Indicator (MBTI), chosen primarily for its relative simplicity, intuitive appeal, and popularity amongst clinicians in working with normal populations. Based on Jung's theory of personality and developed by Isabel Myers for use with non-clinical populations, it has grown rapidly in use since 1976 (McCaulley, 1990) and is considered more an inventory of basic preferences that are somewhat changeable over time and

demand-sensitive, than it is a measure of long-standing personality traits (Myers & McCaulley, 1985). As indicated by Crossman and Polich (1989), Jung's theory of type posits that what appears for the most part to be random variations in human behaviour is actually quite orderly and consistent, since it is caused by certain basic differences in the way individuals prefer to use perception and judgement. The preferences affect not only what people attend to in any given situation, but also how they draw conclusions about what they perceive. These preferences are reflected in the following four bipolar scales:

(1) Extraversion-Introversion (EI) - which measures an individual's preference for the outer world of people as opposed to the inner world of ideas

(2) Thinking-Feeling (TF) - which measures an individual's preference for logic rather than the need for affiliation and feeling

(3) Sensing-Intuition (SN) - which measures an individual's preference for what is observable via the five senses as opposed to the less obvious process of determining meaning, relationships and/or possibilities that have been worked out beyond the conscious mind

(4) Judgement-Perception (JP) - which measures an individual's preference for order and rules as opposed to a preference for flexibility and spontaneity. It reflects the process a person uses

> primarily in dealing with the outer world - the extraverted part of life. A person who prefers judgement has a preference for using a judgement process (either Thinking or Feeling) for dealing with the outer world. A person who prefers perception has a preference for using a perceptive process (either Sensing or Intuition) for dealing with the outer world.

The existence of two preference directions on each of four bi-polar scales (E or I, S or N, T or F, and J or P) yields 16 possible categories or types. For example, an individual may fall into the category INTJ which is interpreted as Introverted, Intuitive, Thinking and Judging.

The Myers-Briggs Type Indicator has found applicability in counselling (individual, family, group and career (Carskadon, 1979; Jones & Sherman, 1979; Provost, 1984)), education (learning/teaching styles, aptitude, achievement and motivation (Brown & Decoster, 1991; Lyons, 1985; Lawrence, 1982, 1984)), organizations (leadership training, career planning, teamwork, participative management (Benfari, 1991; Mitroff & Kilmann, 1975)), and religion (to differentiate ministry and spiritual life (Harbaugh, 1984, 1988)). Also, a segment of research has examined the differences between right and left-brained

functioning, particularly the right-brained function of creativity (Thorne and Gough, 1991), in conjunction with the Myers-Briggs Type Indicator (Crossman & Polich, 1989; Taggart et al., 1991; Shiflett, 1989). The current study suggests the possibility of adding another dimension to the utilitarianism of the Myers-Briggs Type Indicator, by specifically identifying receptivity of clinician and client alike to the use of hypnosis and imagery in dealing with sexual abuse. As an assessment adjunct, such information could assist both in a very meaningful, practical way.

Method

Subjects

Subjects for this study fell into two major categories: practitioner and non-practitioner. As well, individuals in either of these groupings may have classified themselves as a sexual abuse "survivor". Prospective practitioners (psychologists, physicians and crisis centre counsellors) were selected from across the province of Ontario as follows:

- 250 psychologists - chosen randomly from the 1993 Directory of Psychologists Registered in Ontario, systematically alternating selection between male and female, and selecting institutional addresses at a ratio of approximately 1 to 4.
- 611 physicians - chosen randomly from the 1991 College of Physicians and Surgeons Ontario Medical Directory, systematically alternating selection between male, female, general practice and psychiatry.
- 76 psychologists and physicians - registered with the Ontario Society of Clinical Hypnosis, and

selected for their listed interest in sexual problems, psychotherapy, hypnoanalysis, and dissociative states.

. 144 crisis centre counsellors - arising from 36 crisis centres, as listed in the 1993/1994 Northern Ontario Women's Organizations Directory, and on a 1993 listing of Sexual Assault Centres for Southern Ontario. All centres indicating an involvement with the treatment of sexual abuse were contacted first by telephone to solicit participation, and then subsequently mailed 9 survey packages (suggested distribution: 4 for interested counsellors, 5 for interested clients).

Prospective non-practitioner sexual abuse survivors were selected from across the province of Ontario as follows:

. 276 survey packages were included with 67 of the mailings to the psychologists and physicians registered with the Ontario Society of Clinical Hypnosis, requesting voluntary patient

participation at the practitioner's discretion.

. 180 survey packages were included with the mailings to the crisis centres, requesting voluntary client participation at the counsellor's discretion.

Of the 1,081 surveys mailed to practitioners, 291 responses were returned (27%). Of the 456 surveys made available to non-practitioners, 57 responses were received (13%). An additional 18 responses were received but not tabulated in the results, as they were incomplete in some respect (eg. Myers-Briggs Type Indicator not returned or only partially completed; entire survey package returned unanswered, usually with an explanation). As well, 6 usable responses were received after data tabulation had started, and were not included in the results.

It should be emphasized that the non-practitioner sexual abuse survivors who responded to this survey were solicited in an indirect manner (via their respective professionals) and were in various stages of treatment (eg. waiting for treatment, currently being

treated, or finished with their treatment). Data was gathered from all participating subjects over a period of three months (January 1994 - March 1994).

Instruments

Two instruments were utilized to obtain research data. The first was a questionnaire developed specifically for this study (see appendix A). The content of this questionnaire came primarily from the author, and reflects face validity only. However, input was solicited from a sampling of physicians, psychologists and sexual abuse counsellors as well. The questionnaire is comprised of 21 questions designed to categorize the respondent as either practitioner and/or abuse survivor, gather information about abuse incidents, gather information about practitioner sexual abuse treatment practices, identify attitudes concerning hypnosis and imagery, and identify demographic and personal interest information. The questionnaire concludes with the subject's

acknowledgement of information confidentiality, and allows the subject to request the results of the study in general, and/or an individual interpretation of his/her personality if desired.

Each subject completing the questionnaire was also requested to complete the Myers-Briggs Type Indicator (MBTI). The FORM G question booklet was utilized, with a slight modification to directions (acknowledged by the publisher), instructing participants to respond directly in the question booklet instead of on a separate answer sheet (see appendix B). It was thought that this modification would simplify the response process for participants and in some cases reduce the dampening of an individual's initial interest in the survey.

As indicated by Murray (1990) in his review of the research on the MBTI, the Myers-Briggs (M-B) indices of reliability and validity have been extensively investigated and judged acceptable. Split-half reliability for Form G of the instrument (males and females) ranges from .79 to .86 for the 4 M-B indices, derived from the correlations of continuous scores for

the X half and Y half of each index. When reliability is computed considering the indices as dichotomous categories, the general order of magnitude is quite similar.

Test-retest reliabilities of the MBTI show consistency over time. When subjects report a change in type, it is most likely to occur in only one preference, and in scales where the original preference was low. The reliability coefficient for the TF index is the lowest of the 4 scales, with continuous score correlations ranging from .45 to .93 for all scales.

As cited by Murray (1990), the MBTI has found substantial construct support in correlations with other tests of personality, extraversion-introversion and emotionality (eg. MMPI, 16PF, CPI, EPQ, EPI), as well as with behavioural correlates of the four scales in many professions and business organizations. Predictive validity is suggested by several studies which have found the intuitive (N) dimension of the MBTI to be related to academic achievement (Reynolds and Hope, 1970; Schurr, Ruble and Henriksen, 1988), artistic interests (Ireland and Kernan-Schloss, 1983;

O'Haire and Marcia, 1980; Palmiere, 1972), and the kinds of dreams recalled (Cann and Donderi, 1986). Normative data based on students from many liberal arts schools exists, as well as a substantial amount of research on students in a wide variety of professions, medicine, law, business and seminarians.

Procedure

A package of survey material was compiled for each potential participant consisting of:

- a **cover letter** (see appendix C) explaining the following:

  the purpose of the study,
  the requirements - completion of questionnaire and personality inventory, taking approximately 1/2 hour of time
  the voluntary nature of participant participation
  the confidentiality of all information given
  the turn-around time to complete the survey material
  how to return the survey material once completed
  how to request general study results and/or unique personality interpretations

- the **sexual abuse treatment survey**, constructed in booklet form and printed on yellow paper

- the **Myers-Briggs Type Indicator question booklet** (FORM G)

. a **stamped, self-addressed envelope**

Packages intended for practitioners acting as subject pool co-ordinators (ie. those registered with the Ontario Society of Clinical Hypnosis), as well as those sent to participating crisis centres reflected the contents listed above with the exception of specialized cover letters (see appendix D). These alternative cover letters were directed to the contact professional involved at each site, soliciting and explaining voluntary patient/client participation.

861 psychologists and physicians, selected from directories of the Ontario College of Physicians and Surgeons, and the College of Psychologists of Ontario, were each mailed 1 survey package. Crisis centres, selected from the directories of Northern Ontario Women's Organizations and Sexual Assault Centres of Southern Ontario, were approached first by telephone or in person to garner understanding, and once indicating interest, were mailed/delivered 9 survey packages each. Suggested distribution was: 4 packages for interested counsellors, 5 packages for interested clients.

However, the actual distribution was left up to each centre.

As outlined above, survey packages were mailed and occasionally hand-delivered to a total of approximately 1,000 physicians, psychologists and crisis centre counsellors province-wide. As well, 67 practitioners who are currently registered with the Ontario Society of Clinical Hypnosis, were mailed a total of 5 survey packages each, requesting the voluntary involvement of any of their interested patients.

Any survey packages that were returned due to an incorrect address, were re-addressed correctly using a more current directory where possible. Barring that, a new applicable name/address was selected and the package re-mailed. Approximately 100 such re-mailings were done.

Three months were allowed for responses to be returned. During this time, no calls were received from either crisis centres or practitioners acting as resource pool co-ordinators for subjects, despite a contact telephone number being provided to these sources to ensure that no problems were interfering

with the completion of surveys.

As survey packages were returned, the responses recorded by subjects on the Myers-Briggs Type Indicator question booklets were transferred to answer sheets and subsequently hand-scored. Random verification of the transfer process was done to minimize the likelihood of transposition errors.

Data Analysis

Regression analysis was conducted to examine the relationships between hypnotic receptivity (defined as the net result of positive/negative interest, belief, experience and attitude towards hypnosis and imagery as depicted in the sexual abuse treatment survey) and preference type indicator (as depicted by the 8 primary MBTI classifications: EI, SN, TF, JP). These results were examined as well by practitioner, non-practitioner, and sexual abuse survivor.

Additionally, oneway analyses of variance and regression analyses were conducted investigating

relationships between practitioner/non-practitioner groups and the following: SN preference type, JP preference type, gender, learning style, handedness and dream experiences. Data was also grouped according to level of receptivity and experience with hypnosis, resulting in high, medium and low hypnotic receptivity groups, and the above variables were analyzed to determine any inconsistencies in their manifestation. An explanation of grouping criteria is available for reference in appendix E.

Summary statistics regarding abuse history were tabulated. As well, for practitioners, statistics describing the frequency of sexual abuse in their client populations, and the types and efficacy of treatment approaches were summarized.

Results

Characteristics of Sample

The entire sample was comprised of 348 respondents, 110 (31.6%) of which were male and 238 (68.4%) female. The mean age of the 345 respondents who reported age was 46. Of the 341 respondents reporting marital status, 51 (15%) were single, 242 (71%) either married or cohabiting, and 48 (14%) either separated, divorced or widowed.

All responses were initially grouped according to whether the respondent was a practitioner (ie. had indicated being a licensed psychologist, licensed physician or counsellor, or had indicated another occupation (eg. social worker) where treatment of sexually abused individuals was a part of their duties) or a non-practitioner. Practitioner responses totalled 291 (103 (35.4%) male, 188 (64.6%) female). Non-practitioner responses totalled 57 (7 (12.3%) male, 50 (87.7%) female).

The prevalence of a history of some type of sexual abuse was indicated for 155 respondents (44.5% of total

sample). For practitioners the prevalence rate was 102 respondents (35% of all practitioner responses), while for non-practitioners the rate was 53 respondents (93% of all non-practitioner responses). Interestingly, a number of respondents (51 (33% of all reporting sexual abuse)) reported a history of abuse but did not categorize themselves as an abuse "survivor". The total number of respondents who indicated that they provided treatment for sexual abuse was 254 (73% of total sample, 87.3% of all practitioners).

One of the provisions of the questionnaire utilized for this study was to permit feedback to interested participants. There appeared to be a high degree of interest in survey results by those responding to it. Those participants requesting general results of the study totalled 244 (70.1% of entire sample). Those requesting individual personality interpretations based on their MBTI preference type totalled 245 (70.4% of entire sample). The number that requested feedback (general results or personality interpretation or both) and also provided a return mailing address was 257 (73.9% of entire sample). A

small number of respondents (9 - 2.6% of entire sample) requested feedback but neglected to provide a mailing address.

In responding to the questionnaire, participants were asked to categorize themselves in one or more of the following five groupings:

1) abuse survivor
2) licensed psychologist
3) licensed physician
4) counsellor
5) other.

Table 1 depicts a breakdown of these groupings, indicating as well the gender distribution and mean age. Abuse survivor totals are also shown excluding practitioner data. As indicated in Table 1, the "other" category was chosen, either exclusively or not, by 65 respondents. Individuals doing so were primarily comprised of social workers, administrative staff, child care workers, support workers, students and non-practising (retired) physicians. As well, practising physicians, psychologists and counsellors occasionally used this category to supplement their area of

TABLE I RESPONDENT SUMMARY

Response Category (not mutually exclusive)	Number of Responses	Gender		Mean Age	Mean Birth Year
		Males	Females		
1) Abuse Survivor	104	11	93	41	53.25
Practitioner	54	5	49	43	51
Non-Practitioner	50	6	44	39	55.68
2) Licensed Psychologist	80	35	45	49	45.42
3) Licensed Physician	137	64	73	49	45.05
4) Counsellor	64	8	56	43	51
5) Other	65	13	52	43	51.8
Practitioner	50	11	39	44	50.76
Non-Practitioner	15	2	13	39	55.46

expertise by indicating an area of specialization (eg. psychiatry). Of note is the relatively high number of females (both including and excluding practitioners) compared to males, who have classified themselves as abuse "survivors". Also, while the responses from psychologists and physicians show a relatively equal representation of both male and female respondents, the replies from counsellors and other practitioner types such as social workers, etc., indicate a preponderance of female response.

All MBTI preference types were found to be represented in our sample population. As reflected in Figure 1, the most frequently occurring type encountered was INFJ, followed closely by INFP and INTJ. Almost two thirds (60.1%) of all respondents were introverted types, with an even slightly higher percentage (64.4%) preferring a decided intuitive (N) orientation to life. Almost two thirds (59.2%) were judging types.

Some variation in this pattern is evident however, as one focuses in on the various categories of respondents. Figures 2 and 3 depict the percentage of

FIGURE 1 MYERS-BRIGGS PREFERENCE TYPES

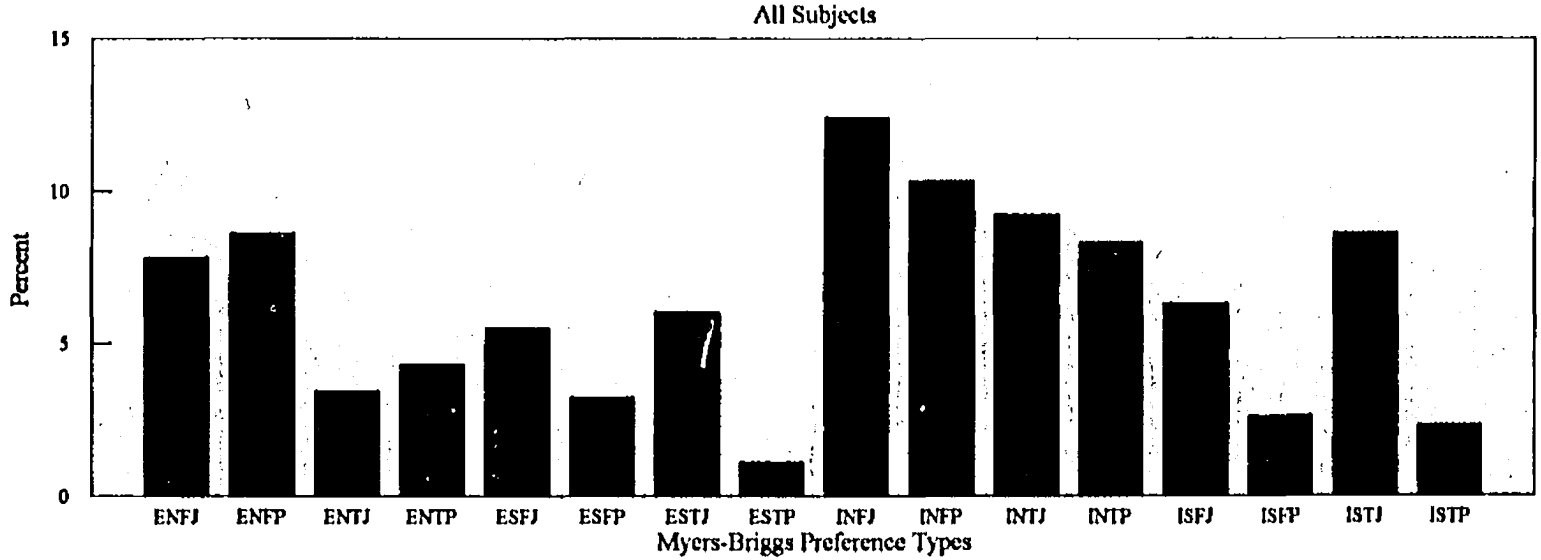


FIGURE 2 MYERS-BRIGGS PREFERENCE TYPES

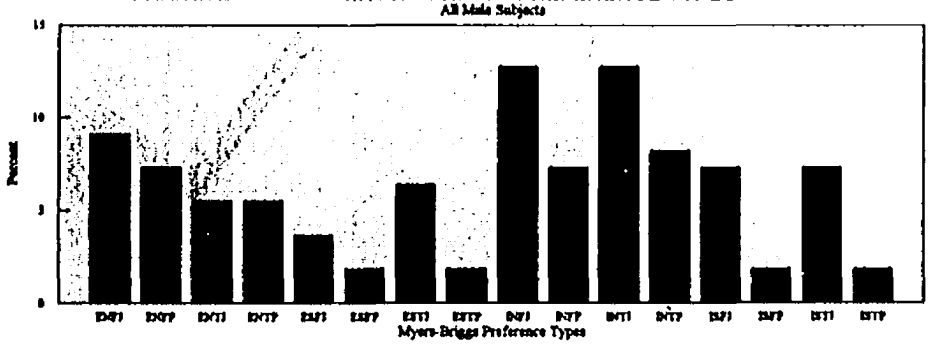
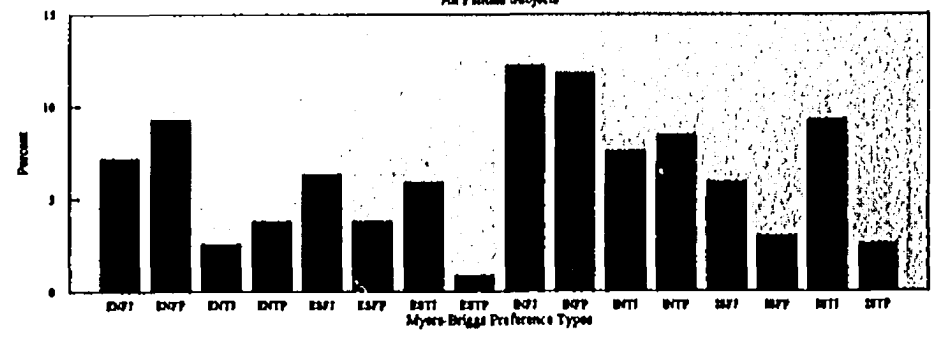


FIGURE 3 MYERS-BRIGGS PREFERENCE TYPES



MBTI preference types found amongst male and female respondents respectively, while Table 4 lists the six most commonly occurring M-B preference types found in our data for practitioners, non-practitioners and abused subjects, allowing comparison to percentage approximations of normative E-I, S-N, and J-P indices. Introverted, intuitive and judging preferences can be seen to predominate amongst male practitioners. Female practitioners as a whole, reflect essentially these same preferences to a slightly greater degree, with the exception of judging which is more equally balanced with M-B types favouring perception. Male non-practitioners appear to favour extraverted, intuitive and perceptive preferences, while female non-practitioners indicated more introverted and sensing preferences. Again, the perceptive and judging preferences were evenly represented amongst these females. Abused males exhibited essentially the same preferences as male practitioners, with an even larger percentage of this grouping preferring an intuitive preference. Abused female preferences appear analogous to the preferences exhibited by female practitioners.

TABLE 4 NORMATIVE COMPARISON OF SIX MOST FREQUENT MBTI TYPES

MBTI Data Bank * Form G Index % ***	Sample Data Type %			SRI VALS ** Index % ***
		Males		
Males	Pract.	Non-Pract.	Abused	Males
E's - 28%	INTJ (13.6)	INFP (28.6)	INFJ (22.2)	E's - 19%
I's - 29%	INFJ (12.6)	INFJ (14.3)	INFP (14.8)	I's - 51%
S's - 29%	ENFJ (8.7)	ESFP (14.3)	INTJ (14.8)	S's - 59%
N's - 28%	INTP (8.7)	ENTJ (14.3)	ENFP (11.1)	N's - 11%
J's - 43%	ISTJ (7.8)	ENFP (14.3)	ENTJ 11.1)	J's - 62%
P's - 14%	ISFJ (7.8)	ENFJ (14.3)	ENFJ (7.4)	P's - 8%
Females		Females		Females
E's - 36%	INFJ (12.8)	INFP (14.0)	INFP (15.6)	E's - 28%
I's - 20%	INFP (11.2)	ESFP (14.0)	ISTJ (10.2)	I's - 41%
S's - 41%	ENFP (10.6)	ISFJ (12.0)	INFJ (9.4)	S's - 70%
N's - 16%	ISTJ (9.6)	INFJ (10.0)	ENFJ (8.6)	N's - 0%
J's - 46%	INTJ (9.0)	ISFP (8.0)	INTP (8.6)	J's - 53%
P's - 10%	INTP (9.0)	ISTJ (8.0)	ISFJ (7.8)	P's - 17%

*MBTI Data Bank reflects scores of 15,791 males and 16,880 females whose records were scored between March 1978 and December 1982.

** SRI VALS reflects scores of 446 males and 659 females (gathered Nationwide).

*** Index percentages are reflective of only the six most frequently occurring MBTI types in the normative populations, and are approximations of actual percentages.

Note. MBTI and SRI VALS percentages adapted from "Manual: A Guide to the Development and Use of the Myers-Briggs Type Indicator", by I. Briggs Myers and M.H. McCaulley, 1985, p. 50-51.

Little direct similarity can be found in matching the MBTI preference types most prevalent in this study to the normative approximations listed in Table 4. The normative populations are generally comprised of a higher percentage of sensing and judging types, and a more equal balance between introverted and extraverted types (eg. ISTJ, ISFJ, ESTJ, ESFJ). However, as evident in Table 5, a much greater similarity to our sample population can be seen in findings reported by Bass et al. (1987), Carskadon (1979), Taylor et al. (1990), and Thorne and Gough (1991, p. 114), where the predominance of MBTI types amongst subjects involved in health care professions (physicians, psychologists, counsellors and clients) more closely resembled our findings.

As well as type differences being characteristic of our sample population, the strength of preference responses also bears mention. As depicted in Table 6, our subjects exhibited a higher percentage of both slight and very clear response preferences amongst sensing male and female practitioners. Sensing non-practitioners were very close to normative ranges. Intuitive practitioners of both sexes demonstrated a

TABLE 5 NORMATIVE COMPARISON OF SIX MOST FREQUENT MBTI TYPES IN HEALTH PROFESSIONS

	Sample Data Type % Males			
Psychiatrists (N=4000+) **	Pract.	Non-Pract.	Abused	Male Medical Students (N=39) *
INFP	INTJ (13.6)	INFP (28.6)	INFJ (22.2)	E's - 25%
INTP	INFJ (12.6)	INFJ (14.3)	INFP (14.8)	I's - 35%
ENFP	ENFJ (8.7)	ESFP (14.3)	INTJ (14.8)	S's - 10%
above types	INTP (8.7)	ENTJ (14.3)	ENFP (11.1)	N's - 50%
significantly	ISTJ (7.8)	ENFP (14.3)	ENTJ 11.1)	J's - 20%
overrepresented	ISFJ (7.8)	ENFJ (14.3)	ENFJ (7.4)	P's - 40%
Psychologists, Psychiatrists, Psychiatric Nurses,	Females			Client Types Seeking Counselling (N=200+) **
Psychiatric Social Workers	INFJ (12.8)	INFP (14.0)	INFP (15.6)	Predominantly
(N=72+) **	INFP (11.2)	ESFP (14.0)	ISTJ (10.2)	N
Approx.	ENFP (10.6)	ISFJ (12.0)	INFJ (9.4)	P (especially
90-95% N's	ISTJ (9.6)	INFJ (10.0)	ENFJ (8.6)	true for males)
66-75% F's	INTJ (9.0)	ISFP (8.0)	INTP (8.6)	
	INTP (9.0)	ISTJ (8.0)	ISFJ (7.8)	
Family Practice Residents (N=778) ****				Medical Students (N=675) ***
63% N's				INFP (10.2)
61% F's				ISTJ (9.3)
				ESTJ (8.4)
				ENFP (8.3)
				INFJ (8.1)
				INTP (7.6)

* From "Portraits of Type", by A. Thorne and H. Gough, 1991, p. 114. Percentages are reflective of only the six most frequently occurring MBTI types, and are approximations of actual percentages.

** From "Clinical and Counseling Aspects of the Myers-Briggs Type Indicator: A Research Review," by T.G. Carskadon, 1979, Research in Psychological Type, 2, p. 3-4.

*** From "Medical Students and Dental Students: Are They the same in Goals and Aspirations? In Type?," by R.K. Bass, A.D. King and J.A. Hollway, 1987, Educational and Psychological Research, 7(3), p.157.

**** From "Personality Types of Family Practice Residents in the 1980's", by A.D. Taylor, C. Clark and A.E. Sinclair, 1990, Academic Medicine, March, p. 217.

TABLE 6 MBTI DEGREE OF PREFERENCE COMPARISON

Degree Of Preference		Normative Scale % * (M=15,791) (F=16,880)	Sample Scale % All Subjects	Pract.	Non-Pract.	Abused
Sensing Males	S		(N=35)	(N=34)	(N=1)	(N=3)
Slight		20 - 25	31.4	32.4	0.0	0.0
Moderate		20 - 25	14.3	14.7	0.0	33.3
Clear		35 - 40	28.6	26.5	100.0	33.3
Very Clear		15 - 20	25.7	26.5	0.0	33.3
Sensing Females			(N=89)	(N=62)	(N=27)	(N=50)
Slight		20 - 25	29.2	32.3	22.2	22.0
Moderate		20 - 25	22.5	21.0	25.9	22.0
Clear		35 - 40	28.1	24.2	37.0	36.0
Very Clear		15 - 20	20.2	22.6	14.8	20.0
Intuitive Males	N		(N=75)	(N=69)	(N=6)	(N=24)
Slight		25 - 30	9.3	10.1	0.0	4.2
Moderate		20 - 25	29.3	27.5	50.0	25.0
Clear		35 - 40	41.3	42.0	33.3	45.8
Very Clear		10 - 15	20.0	20.3	16.7	25.0
Intuitive Females			(N=149)	(N=126)	(N=23)	(N=78)
Slight		25 - 30	16.8	15.9	21.7	16.7
Moderate		20 - 25	23.5	19.8	43.5	25.6
Clear		35 - 40	40.9	42.1	34.8	38.5
Very Clear		10 - 15	18.8	22.2	0.0	19.2
Judging Males	J		(N=71)	(N=68)	(N=3)	(N=17)
Slight		20 - 25	21.1	19.1	66.7	35.3
Moderate		20 - 25	18.3	19.1	0.0	23.5
Clear		35 - 40	42.3	42.6	33.3	35.3
Very Clear		15 - 20	18.3	19.1	0.0	5.9
Judging Females			(N=135)	(N=111)	(N=24)	(N=66)
Slight		20 - 25	22.2	18.0	41.7	28.8
Moderate		20 - 25	22.2	22.5	20.8	24.2
Clear		35 - 40	37.8	42.3	16.7	31.8
Very Clear		15 - 20	37.8	17.1	20.8	15.2
Perceptive Males	P		(N=39)	(N=35)	(N=4)	(N=10)
Slight		25 - 30	12.8	11.4	25.0	20.0
Moderate		20 - 25	23.1	25.7	0.0	30.0
Clear		30 - 35	48.7	51.4	25.0	10.0
Very Clear		15 - 20	15.4	11.4	50.0	40.0
Perceptive Females			(N=103)	(N=77)	(N=26)	(N=62)
Slight		25 - 30	27.2	28.6	23.1	25.8
Moderate		20 - 25	18.4	18.2	19.2	21.0
Clear		30 - 35	34.0	32.5	38.5	40.3
Very Clear		10 - 15	20.4	20.8	19.2	12.9

* Percentage ranges adapted from "Manual: A Guide to the Development and Use of the Myers-Briggs Type Indicator", by I. Briggs Myers and M.H. McCaulley, 1985, p. 59.

stronger tendency towards clarity in their responses than the norm, as did abused subjects in general, whether preferring sensing or intuition. Intuitive non-practitioners indicated a greater percentage of moderate responding. The judging preferences of our sample are fairly close to the norms, with the exception of female non-practitioners who indicated a greater percentage of slight preference. For perceptive males in all groupings, decidedly clearer preferences were common. This leaning towards clarity was also true for perceptive females, but to a lesser degree.

Hypnotic Receptivity

For the purpose of this study, hypnotic receptivity was operationally defined as the net result of the combination of one or more of the following:

- a positive interest in hypnosis for oneself/others
- a positive belief in the efficacy of hypnosis
- experience with hypnosis regarding oneself and/or others
- a positive belief in the efficacy of imagery/visualization techniques

. experience with imagery/visualization techniques
. a negative interest in hypnosis for oneself and/or others
. a negative belief in the efficacy of hypnosis
. a negative belief in the efficacy of imagery/visualization techniques

A measure of hypnotic receptivity (RECEPT) was computed for each respondent as their accumulation of endorsements to questions related to the above criteria (see appendix F for mapping of applicable questions). Finer breakdowns were computed as well as follows:

. positive interest and belief in hypnosis (HYPPOS),
. experience with hypnosis on oneself and/or others (HYPEXP),
. neutral interest/belief/experience with hypnosis (HYPNEU),
. negative interest/belief/experience with hypnosis (HYPNEG),
. positive belief in imagery/visualization (IMAGPOS),
. experience with imagery/visualization (IMAGEXP),
. neutral belief in imagery/visualization (IMAGNEU),

. negative belief in imagery/visualization (IMAGNEG).

Twice as many opportunities existed amongst the possible responses for respondents to reply positively. As a result, if respondents indicated having had experience with hypnosis, any negative endorsements made by them were doubly weighted, in order to offset any bias (ie. if HYPEXP greater than 0 then HYPNEG = HYPNEG X 2). Hypnotic receptivity (RECEPT) was therefore computed as (HYPPOS + HYPEXP + IMAGPOS + IMAGEXP) - (HYPNEG + IMAGNEG) for each respondent.

The preference scores of the 4-character M-B type for each respondent were converted from dichotomous scores to continuous scores for regression analysis purposes, following the convention outlined by Myers and McCaulley (1985). Using regression analysis on the entire sample, the converted SN variable of each M-B type was found to be statistically significant in predicting hypnotic receptivity ($F(1,346) = 42.270$, $p < .001$). This finding suggests that the higher an individual's intuitive (N) score, the more likely

he/she was to have tried hypnosis and/or imagery/visualization techniques, and/or to possess a positive attitude towards both. Figure 4 provides a graphic illustration of this regression of receptivity to slight, moderate and very clear preference levels of SN. As the preference for S decreases in moving from very clear to slight, and the preference for N correspondingly increases, receptivity increases. This relationship was upheld in further regression analyses of hypnotic receptivity and sensing/intuition (SN) for practitioners only ($F(1,289) = 30.183$, $p < .001$) and for non-practitioners only ($F(1,55) = 11.440$, $p = .001$). Abused subjects demonstrated the same strong relationship ($F(1,153) = 34.100$, $p < .001$), as did subjects considering themselves "survivors" ($F(1,102) = 18.038$, $p < .001$). Overall, regression analysis of hypnotic receptivity and judging/perception (JP) did not find a significant relationship to exist ($F(1,346) = .13724$, $p = .711$). However, significant results were found when other practitioners ($F(1,8) = 3.931$, $p = .08$) and abused practitioners ($F(1,100) = 2.990$, $p = .08$) were considered separately.

FIGURE 4 REGRESSION OF RECEPTIVITY TO DIFFERENT LEVELS OF SN

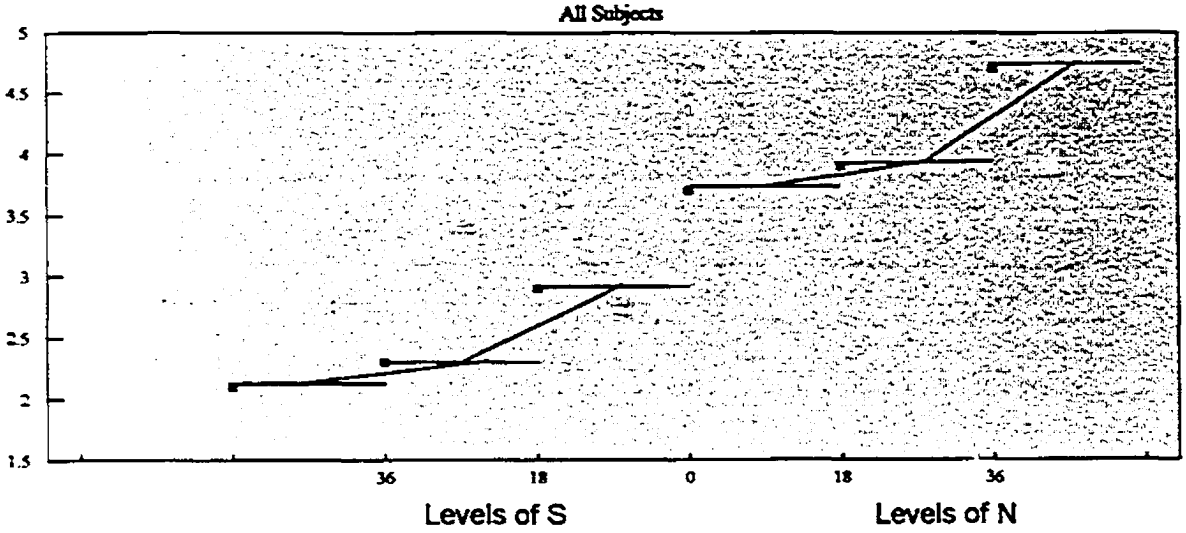


Table 10 depicts T-test results which uphold the regression findings noted above. These results are of interest as they incorporate the inherent dichotomous nature of the Myers-Briggs Type Indicator, producing virtually the same strong finding regarding the relationship between receptivity and the intuitive (N) preference.

The means for all variables utilized in the computation of receptivity are tabulated in Tables 2 and 3. Of note in Table 2 is the consistent increasing receptivity depicted, whether practitioner or non-practitioner, between non-abused subjects, those reporting abuse, and those categorizing themselves as "survivors". Of note as well is the order of hypnotic receptivity found in this study, which from highest to lowest is as follows: psychologists, physicians, non-practitioners, other practitioners, and counsellors. However, when receptivity to imagery/visualization (IRECEPT) is considered separately, the order changes to psychologists, counsellors, other practitioners, non-practitioners, and physicians.

TABLE 10 MBTI and Receptivity T-Tests

Receptivity Measures	Sensing Subjects N	Mean	SD	Intuitive Subjects N	Mean	SD	t	df	p ****
Overall Receptivity (RECEPT) *									
All Subjects	124	2.5	2.36	224	4.06	2.55	5.61	346	<.001
Practitioner - All	96	2.66	2.40	195	4.02	2.49	4.42	289	<.001
- Abused	27	1.77	2.29	75	4.29	2.78	4.24	100	<.001
***** - Other	19	2.37	2.50	31	3.87	2.66	1.99	48	.05
All Non-practitioners	28	1.93	2.19	29	4.31	2.95	3.45	55	.001
* Range = -5 to 12									
Hypnosis Receptivity (HRECEPT) **									
All Subjects	124	1.68	1.91	224	2.58	2.00	4.09	346	<.001
Practitioners - All	96	1.80	1.92	195	2.58	1.98	3.24	289	.001
- Abused	27	.85	1.94	75	2.59	2.28	3.52	100	.001
- Other	19	1.26	2.18	31	2.39	2.25	1.74	48	.09
All Non-Practitioners	28	1.29	1.86	29	2.59	2.29	2.35	55	.02
** Range = -5 to 9									
Imagery Receptivity (IRECEPT) ***									
All Subjects	124	.83	.88	224	1.48	.95	6.35	346	<.001
Practitioner - All	96	.68	.89	195	1.44	.91	5.02	289	<.001
- Abused	27	.93	.83	75	1.71	.93	3.86	100	<.001
- Other	19	1.11	.88	31	1.48	.85	1.51	48	.14
All Non-Practitioners	28	.64	.83	29	1.72	1.13	4.11	55	<.001
*** Range = 0 to 3									

**** Represents Pooled Variance Estimates in all cases.

***** Represents abused and non-abused practitioners in the "other" category.

TABLE 2 MEANS OF HYPNOSIS/IMAGERY ATTITUDE AND EXPERIENCE

	All Subjects			Practitioners								Non- Practitioners			
					Specific Practitioner										
Hypnosis/ Imagery Measures	All Subjects (N=348)	All Subjects Abused (N=155)	All "Survivors" (N=104)	All Practitioners (N=291)*	Psych. (N=80)	Physicians (N=137)	Counsellors (N=64)	Other (N=19)	Pract. No Abuse (N=189)	Pract. Abused (N=102)	Pract. "Survivors" (N=54)	Non-Pract. (N=57)	Non-Pract. No Abuse (N=4)	Non-Pract. Abused (N=53)	Non-Pract. "Survivors" (N=50)
Hyppos	1.7989	1.7935	1.8558	1.7973	1.9875	1.8029	1.5625	1.5789	1.8201	1.7549	1.8148	1.807	1	1.8679	1.9
Hypneu	0.7299	0.8387	0.8077	0.7216	0.575	0.6496	1	0.9474	0.6402	0.8725	0.8519	0.7719	0.75	0.7736	0.76
Hypneg	0.2241	0.3484	0.3846	0.1993	0.1125	0.1168	0.4375	0.3684	0.1217	0.3431	0.3889	0.3509	0.25	0.3585	0.38
Hypexp	0.6839	0.6452	0.6538	0.7216	0.8875	0.8321	0.3594	0.4737	0.7249	0.7157	0.7593	0.4912	0.25	0.5094	0.54
Imagpos	0.1006	0.2258	0.3173	0.0584	0.0375	0.0219	0.1406	0.1053	0	0.1667	0.2778	0.3158	0	0.3396	0.36
Imagneu	0.0287	0.0645	0.0769	0.0241	0.025	0.0146	0.0313	0.0526	0	0.0686	0.0926	0.0526	0	0.0566	0.06
Imagneg	0.0115	0.0258	0.0385	0.0069	0	0	0.0156	0.0526	0	0.0196	0.037	0.0351	0	0.0377	0.04
Imagexp	1.1552	1.2129	1.1538	1.2027	1.625	0.927	1.2813	1.1579	1.1217	1.3529	1.2963	0.9123	0.5	0.9434	1
Hrecept	2.2586	2.0903	2.125	2.3196	2.7625	2.5182	1.4844	1.6842	2.4233	2.1275	2.1852	1.9474	1	2.0189	2.06
Irecept	1.2433	1.4129	1.4327	1.2543	1.6625	0.9489	1.4063	1.2105	1.1217	1.5	1.537	1.193	0.5	1.2453	1.32
Recept	3.5029	3.5032	3.5577	3.5739	4.425	3.4672	2.8906	2.8947	3.545	3.6275	3.7222	3.1404	1.5	3.2642	3.38

* Specific practitioner totals exceed that of all practitioners. Reason: 9 practitioners categorized themselves in 2 practitioner categories each.

TABLE 3 MEANS OF MYERS-BRIGGS CONTINUOUS SCORES

	All Subjects			Practitioners								Non- Practitioners			
M-B Index	All Subjects (N=348)	All Subjects Abused (N=155)	All "Survivors" (N=104)	All Practitioners (N=291)*	Specific Practitioner: Psych. (N=80)	Physicians (N=137)	Counsellors (N=64)	Other (N=19)	Pract. No Abuse (N=189)	Pract. Abused (N=102)	Pract. "Survivors" (N=54)	Non-Pract. (N=57)	Non-Pract. No Abuse (N=4)	Non-Pract. Abused (N=53)	Non-Pract. "Survivors" (N=50)
E (extraversion)	82.5827 (N=139)	83.6 (N=60)	83.2326 (N=43)	82.4655 (N=116)	78.1875 (N=32)	85.84 (N=50)	81.8966 (N=29)	82.7143 (N=7)	81.6579 (N=76)	84 (N=40)	83.4 (N=25)	83.1739 (N=23)	85.6667 (N=3)	82.8 (N=20)	83 (N=18)
I (introversion)	123.7177 (N=209)	123.3368 (N=95)	123.459 (N=61)	123.4 (N=175)	122.3333 (N=48)	125.7356 (N=87)	120.5429 (N=35)	117.3333 (N=12)	124.115 (N=113)	122.0968 (N=62)	121.1379 (N=29)	125.3529 (N=34)	115 (N=1)	125.6667 (N=33)	125.5625 (N=32)
S (sensing)	76.7742 (N=124)	74.9623 (N=53)	74.5882 (N=34)	77.0417 (N=96)	77.5 (N=20)	77.7308 (N=52)	73.9 (N=20)	77.5714 (N=7)	78.0725 (N=69)	74.4074 (N=27)	74.6364 (N=11)	75.8571 (N=28)	80 (N=2)	75.5385 (N=26)	74.5652 (N=23)
N (intuition)	126.0179 (N=224)	126.3137 (N=102)	124.9429 (N=70)	126.9282 (N=195)	126.9333 (N=60)	127.6353 (N=85)	127.1364 (N=44)	122.1667 (N=12)	125.8833 (N=120)	128.6 (N=75)	128.0698 (N=43)	119.8966 (N=29)	119 (N=2)	119.963 (N=27)	119.963 (N=27)
T (thinking)	78.4967 (N=151)	82.1228 (N=57)	84.1579 (N=38)	77.5185 (N=135)	75.2162 (N=37)	77.0984 (N=61)	77.56 (N=25)	84.5714 (N=14)	76.0652 (N=92)	80.6279 (N=43)	82.04 (N=25)	86.75 (N=16)	87 (N=2)	86.7143 (N=14)	88.2308 (N=13)
F (feeling)	118.5228 (N=197)	117.7755 (N=98)	119.3636 (N=66)	118.1923 (N=156)	118.4419 (N=43)	118.2105 (N=76)	119.7692 (N=39)	114.6 (N=5)	119.268 (N=97)	116.4237 (N=59)	118.931 (N=29)	119.7805 (N=41)	119 (N=2)	119.6205 (N=39)	119.7027 (N=37)
J (judgement)	75.466 (N=206)	78.9036 (N=83)	81.3077 (N=52)	74.7765 (N=179)	72.1071 (N=56)	73.8966 (N=87)	81.129 (N=31)	74.8182 (N=11)	73.4202 (N=119)	77.4667 (N=60)	79.4 (N=30)	80.037 (N=27)	65 (N=4)	82.6522 (N=23)	83.9091 (N=22)
P (perception)	124.1549 (N=142)	122.6944 (N=72)	123.9615 (N=52)	124.0179 (N=112)	123.1667 (N=24)	123.72 (N=50)	128.6364 (N=33)	117.75 (N=8)	125.6571 (N=70)	121.2857 (N=42)	121.9167 (N=24)	124.6667 (N=30)	0 (N=0)	124.6667 (N=30)	125.7143 (N=28)

* Specific practitioner totals exceed that of all practitioners. Reason: 9 practitioners categorized themselves in 2 practitioner categories each.

Differences in MBTI type preferences pertinent to practitioner/non-practitioner grouping can be seen by examining the means depicted in Table 3. As a whole, non-practitioners have demonstrated less of an intuitive (N) preference than practitioners. They also indicate slightly more feeling (F) and perceiving (P) preferences than practitioners.

MBTI Preference Strength and Receptivity Level

In order to understand more specifically the effects of preference level on our population, analyses of receptivity means and dichotomous M-B indices were conducted, as reflected in Figures 5 through 8. In Figure 5, mean receptivity was plotted against 3 levels of SN for each of practitioner, non-practitioner and abused subject groups. For abused subjects and practitioners, as the preference for sensing (S) lessened, the level of receptivity rose. For non-practitioners, receptivity rose as sensing preference approached the moderate level, but decreased as preference continued to weaken. With levels of intuitiveness (N), as preferences for N strengthened,

FIGURE 5 MEAN RECEPTIVITY AT DIFFERENT LEVELS OF SN

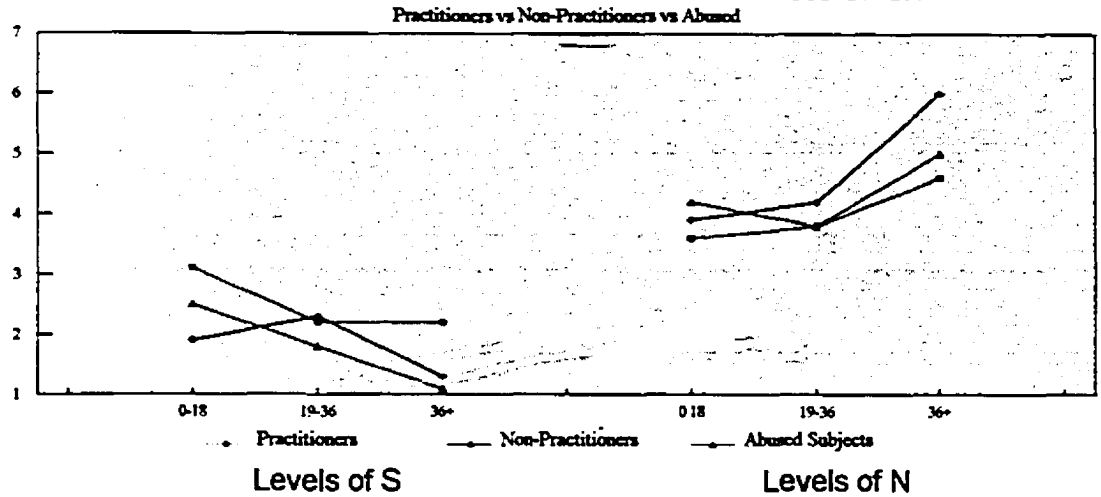
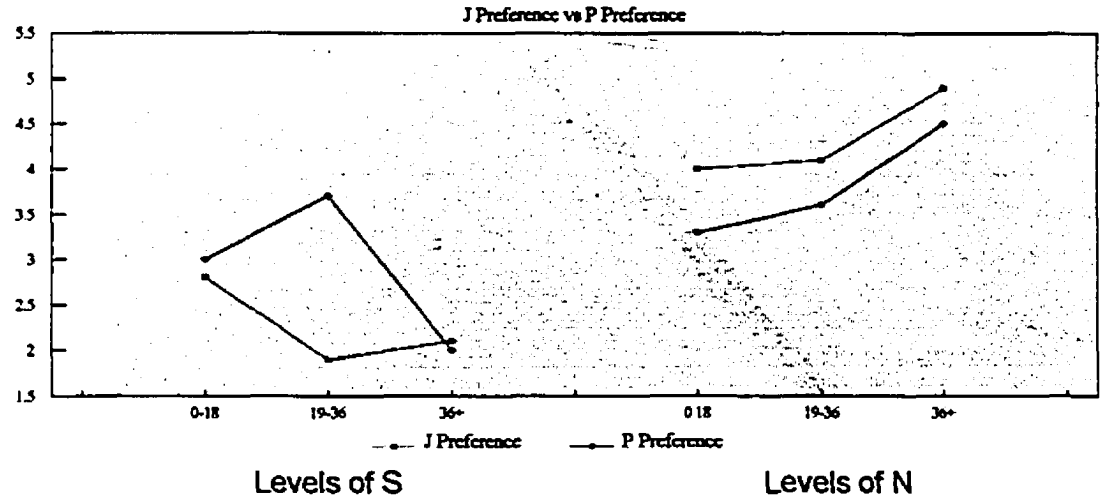


FIGURE 6 MEAN RECEPTIVITY AT DIFFERENT LEVELS OF SN



receptivity of both practitioners and non-practitioners increased. Abused subjects experienced a decline in receptivity at moderate levels of N, which rose again as N preferences strengthened. Overall, of note is the clear indication of a receptivity higher than at any level of S, at even the lowest levels of N.

Figure 6 examines the effects of judging (J) and perception (P) on receptivity. With intuitive subjects, J and P were found to operate similarly (ie. as N preference strengthened, receptivity rose). With sensing subjects, at moderate levels of S receptivity for J subjects decreased and then rose again at the slight preference level of S. With P subjects, receptivity peaked at the moderate level of S, matching the same degree of receptivity as P subjects possessing moderate N preferences. At the slight preference level of S, receptivity in P subjects declined to almost the same point as in J subjects.

The effects of sensing/intuitive (SN) preference level were seen to be quite similar for all subjects regardless of the level of receptivity they exhibited. Generally, as depicted in Figure 7, as strength of

either preference increased to the moderate range, receptivity rose marginally before declining again in subjects with very clear preferences. A notable exception to this can be seen in the least receptive intuitive subjects, whose receptivity decreased at moderate levels of N, and increased as their preference became clearer. Also, sensing subjects in the mid-receptivity group showed a gradual increase in receptivity as their sensing preference weakened.

Preference level appeared to have a different effect upon receptivity when judging/perception (JP) was examined in subjects of varying receptivity. As illustrated in Figure 8, receptivity gradually increased as preference strength weakened. This relationship appeared true for the most receptive subjects of either J or P preference, and also for the least receptive subjects of J preference. The reverse relationship, where receptivity more abruptly increased as J preference became stronger was found for subjects of mid-receptivity. The mid and least receptive groupings reflecting a P preference were both at their lowest levels of receptivity in subjects with a very

FIGURE 7 MEAN RECEPTIVITY AT DIFFERENT LEVELS OF SN

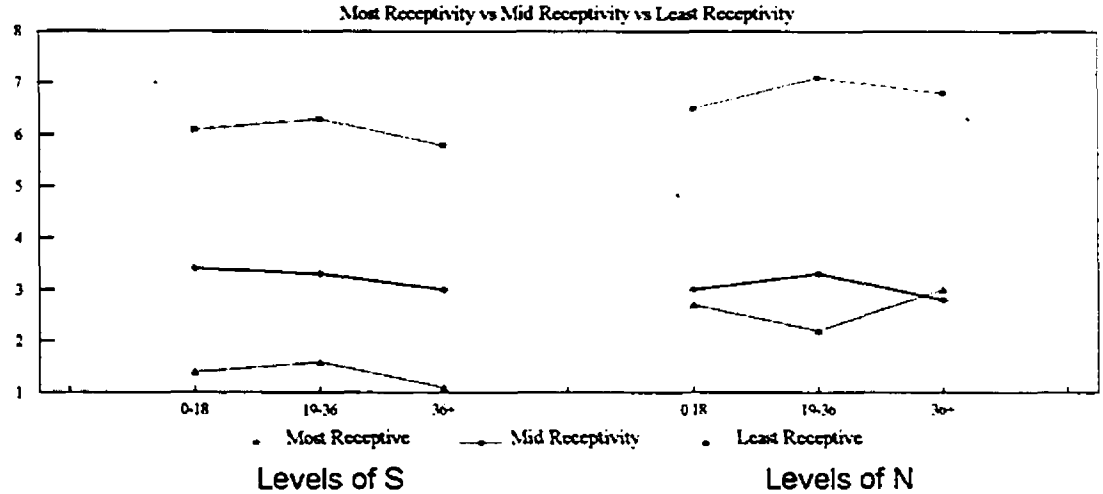
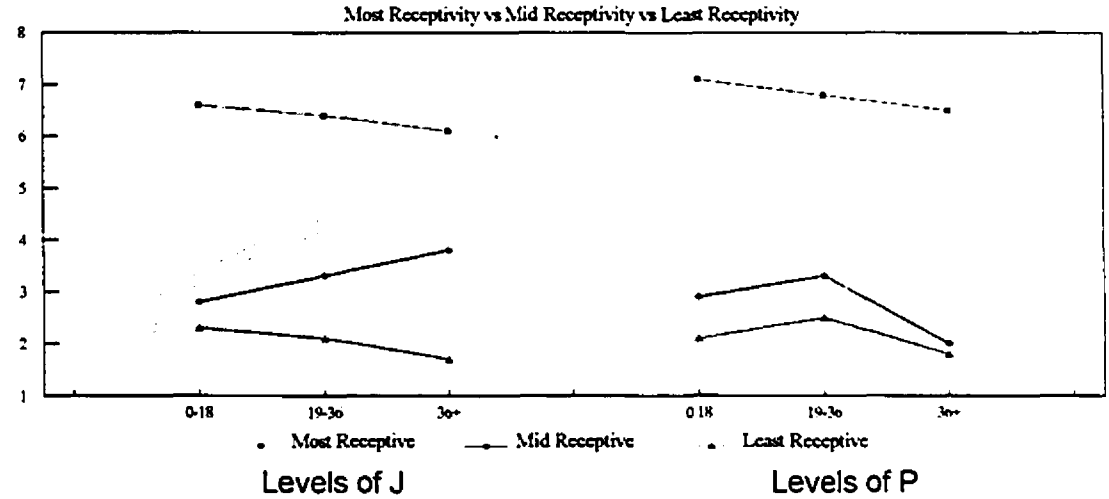


FIGURE 8 MEAN RECEPTIVITY AT DIFFERENT LEVELS OF JP



clear preference. In these groupings, receptivity levels were highest when P preferences were of moderate strength, and decreased slightly as P preferences became weaker.

Other Variables

Gender was found to have a bearing on receptivity only for non-practitioners ($F(1,55) = 8.181$, $p = .006$). Learning preference did not bear a relationship to receptivity ($F(2,340) = 1.487$, $p = .227$). Hand preference showed a significant relationship to receptivity for non-practitioners only ($F(2,54) = 2.213$, $p = .11$). A rich dream experience (defined as subject endorsement of dream recall response 1 or 2, and endorsement of dream frequency response 1, 2, or 3) and receptivity were found to be significantly related for subjects overall ($F(1,346) = 6.362$, $p = .012$). This relationship appeared quite strong for practitioners ($F(1,289) = 9.293$, $p = .002$), but not so for non-practitioners ($F(1,55) = .173$, $p = .67$). More specifically, receptivity and dream frequency were found to be significantly related in subjects

exhibiting an intuitive (N) preference ($F(1,222) = 8.958$, $p = .003$), and a judging (J) preference ($F(1,204) = 20.027$, $p < .001$). Examination of the relationship between receptivity and dream experiences amongst high, mid and low receptivity subject groups revealed no significant variation in receptivity based on the dream experiences of subjects within each grouping, or between each grouping.

Abuse Statistics

Table 7 (see appendix H) provides a summary of the data particular to practitioner-related responses. Crisis centre counsellors encountered the highest percentage of female sexual abuse in their clients (70%), while psychologists reported the highest percentage of male sexual abuse in their clientele (14%). The average prevalency of sexual abuse in the populations seeking the services of the practitioners who participated in this study was 10% for male and 36% for female patients/clients.

The most popular therapeutic approaches used by practitioners in treating sexual abuse were approaches

other than those listed on the survey, such as referral to specialized treatment facility, cognitive therapy, etc. This was followed closely by client-centered therapy, brief psychotherapy, and multi-modal therapy. The therapeutic approach endorsed the least was psychoanalysis.

Practitioners tended to rate the effectiveness of their "other" therapies the highest (8.0). Client-centered therapy (6.5), multi-modal therapy (6.3) and hypnosis (6.2) followed in that order.

As indicated in Table 8 (see appendix I), 25% of all male respondents reported sexual abuse, while 54% of all female respondents did so. Most male abuse took place in childhood. For females however, only half experienced their abuse solely in childhood, with the remainder experiencing abuse in adulthood, or both childhood and adulthood. The average age at abuse commencement was 10 for both males and females.

As depicted in Table 9 (see appendix J), most abused subjects experienced their abuse by an individual known to them, as opposed to a stranger (11.2%). The most common frequency for the abuse was

from 1 to 10 times, with a single episode (1 day duration) true for the greatest percentage of abused subjects (14.6%). However, the next most highly endorsed duration was more than 10 years (6.9%).

Discussion

In summarizing the results of this study, notable similarities and differences between practitioners and non-practitioners emerge. The predominant finding was of a strong, stable tendency in all subjects regardless of grouping, to possess more favourable attitudes/receptivity towards hypnosis as the magnitude of their preference for intuitiveness (N) increased. Also, both practitioner and non-practitioner groups evidenced an increasing receptivity to hypnosis as firstly, abuse was reported as a part of their lives and secondly, as their response to abuse was reported in "survivor" terminology.

Differences between the groups covered a number of areas. For the practitioner group, a more active dream life was related to increased receptivity to hypnosis.

For the non-practitioner group, both gender and hand preference appeared related to receptivity. Preference strength differentially affected receptivity based on non-practitioner/practitioner grouping.

The relationship of judging/perception (JP) to receptivity produced mixed, unexpected findings. Only some practitioners (those in the "abused" and "other" categories) demonstrated measures of JP related to receptivity. Also, regardless of JP preference, receptivity still increased as the magnitude of intuitiveness (N) increased.

Both SN and JP preferences appeared to operate relatively consistently, regardless of the level of receptivity (high, moderate or low). Exceptions centered primarily around the moderate receptivity level. The remaining discussion will focus attention on each of these summary areas.

Sensing/Intuition (SN)

Our finding of the strong influence of intuitive (N) preference upon hypnotic receptivity came as no surprise. Reasons for this are based upon a number of

factors. As defined by Myers and McCaulley (1985), intuition (N) refers to the perception of possibilities, meanings and relationships beyond what is immediately observable via the five senses. As a result, it is believed that individuals with an intuitive perception may develop characteristics that can follow from emphasis on intuition, and become imaginative, theoretical, abstract, future-oriented, or creative.

Hypnosis is a concept that is as yet still theoretical, existing since its inception with Franz Mesmer (1733-1815) in a shroud of mystery. The workings of mind-techniques such as visualization and hypnosis are not immediately obvious and generally not well understood, as indeed is true of the mind itself. Recent advances in areas of science such as neuroendocrinology, neuroimmunology and molecular genetics are beginning to reveal underpinnings, and provide concrete, empirical evidence of mind-body communication (Smith et al., 1985; Pert et al., 1985; Hampson and Kimura, 1988; Rossi, 1990). Despite this though, as yet there are no widely accepted underlying

principles, for those that would be inclined to give credence to them. By virtue of inference then, the individual characteristically more open to possibilities would be the one more likely to consider the use of a more obscure, controversial option such as hypnosis.

As stated by Thorne and Gough (1991, p.74), a key element of the intuitive personality is the imaginative reconstruction of what is seen as the dull and uneventful world of reality. Imagination is central to intuition (N) as measured by the MBTI, a connection which has been reinforced via association with various other personality instruments. Intuition has been found associated with imagination, independence and creativity on the 16PF; with theoretical and aesthetic interests on the Allport-Vernon-Lindzey Study of Values (AVL); with intellectuality and creativity on the Opinion, Attitude and Interest Survey; and with theoretical orientation, estheticism, complexity, autonomy, and thinking on the Omnibus Personality Inventory (OPI) (Lawrence, 1984). Also, research has found that both fantasy and imagery are of more

interest to intuitive types (O'Haire and Marcia, 1980) and additionally, significant differences exist concerning the content and affect of these images (Ireland and Kernan-Schloss, 1983; Palmiere, 1972).

As outlined earlier in this paper, various researchers have identified the central role that imaginative involvement plays in both the process of hypnosis and in the manifestation of post-traumatic stress. To reiterate Spiegel (1988, p. 27), the "use of images in hypnosis can be especially vivid and productive, since imagery is a prominent feature of PTSD symptomatology (Brett and Ostroff, 1985)". But, whether the trauma of abuse increases hypnotic receptivity, or whether receptive individuals may be more susceptible to abuse is a moot question. However, question regarding the hypnotizability of traumatized individuals is not, with confirmatory relationships having been found by a number of researchers (Hilgard, 1970; Spiegel et al., 1988; Stutman and Bliss, 1985).

Our results tend to lean in this direction as well. As a group, the individuals who reported some type of abuse in their backgrounds exhibited a greater

level of overall receptivity to imagery and hypnosis than those who reported no abuse. Furthermore, of the individuals who reported abuse, those who considered themselves "survivors" exhibited the highest levels of receptivity of all. It would appear that as the subjective meaning of the abuse heightened, so did receptivity.

Some aspects of this finding warrant amplification though. It may well be that the use of "survivor" terminology by the subjects reflects a greater emotional wound, and hence a greater need to resolve or heal, by any means. What is interesting to note is the one exception to the above trend, that being the finding of the greatest receptivity to hypnosis amongst non-abused practitioners, not abused practitioner "survivors". This is implying that something other than a personal need for self-healing is underlying the strong interest in hypnosis for practitioners. For non-practitioners however, increased receptivity appears to mirror increased emotional impact.

The above statements can be made by implication only, as no gradated measures of emotional trauma were

ascertained in this study. Substantiation of the relationship between degree of traumatization and receptivity in the future could help to clarify this issue. Additionally, an examination of the strength of intuitiveness (N) amongst abused subjects could confirm if abused "survivors" reflected stronger (N) preferences than abused "non-survivors". Such investigations could help focus on whether abuse or intuitiveness (N) plays the bigger part in influencing hypnotic receptivity. Additionally, consideration of treatment stage and practitioner style and emphasis may prove significant in revealing further subtleties related to the subjective meaning of "survivor".

Other Variables

Substantial research into the relationship between creativity and the MBTI scales has found the intuitive (N) preference to be consistently related to creativity, and the perceptive (P) preference frequently related (Thorne and Gough, 1991, p. 67). For both sexes, NP types were found to be generally higher

on creativity than SJ types. Related to this, a study by Crossman and Polich (1989) examined left- and right-brain processing in conjunction with the Myers-Briggs. Findings indicated that individuals preferring right-brained functioning scored primarily in the intuitive (N) and perceptive (P) ranges. It has been recognized via split-brain studies that the right hemisphere is predominantly active during hypnosis (Hilgard, 1986). It plays a major role in dreaming, with research results "strongly suggest(ing) a specific complementary relationship between REM sleep and right-brain activity" (Joseph, p. 272, 1992), as well as evidencing specialization regarding spatial, artistic and musical abilities (Springer and Deutsch, 1981). Connections are being tentatively drawn between ultradian rhythms of brain function and the hypnotic trance state, with the idea proffered of hypnosis functioning as a truly "permissive" technique designed to enhance and facilitate intrinsic biological rhythms (Brown, 1991). Creativity, dreaming and the hypnotic state - all appear predominantly influenced by the right hemisphere of the brain, the use of which in turn, has been shown

by conflicting research to bear either a weak (Shiflett, 1989) or strong (Taggart et al., 1991) relationship to intuitive preference as measured by the Myers-Briggs Type Indicator.

Our results lend support for the stronger association between intuitiveness and right hemisphere processing. Practitioners in our study were found to recall significantly more dreams than non-practitioners, and possessed notably stronger intuitive (N) and judging (J) preferences than non-practitioners. Granted, there may be other factors particular to being a practitioner that may affect their frequency of dreaming, and/or influence their recollection and reporting of this behaviour. The absence of cause/effect evidence is an inherent confound in any relational research. However, that being the case, the retrospective information gathered via this study offers some support for data accumulating in this area (Cann and Donderi, 1986; Cohen, 1970; Jacka, 1990).

Within our data, a moderately significant relationship was found to exist between gender, handedness, and receptivity for the non-practitioner

group of subjects. Initially, this was a surprising finding, as differences were not anticipated regarding gender. Even more surprisingly, the 7 males in this group evidenced significantly more receptivity than did the 50 females. All males were abuse survivors except one, who reported being in an executive position in a crisis centre. Also, an intuitive (N) preference and a feeling (F) preference were reported by 6 of 7 males, while an extraverted (E) preference and a perceptive (P) preference were reported by 4 males. Data for these subjects can be referenced in appendix G.

Unfortunately, this subject grouping is relatively small, allowing at best only tenuous speculation. What is clearly apparent among these subjects is their predominant N (future-oriented) and F (feeling-oriented) preferences. Also, they all have issues of either personal or professional abuse to deal with.

Only in the last decade has research started to systematically examine the impact of sexual abuse on males. On the whole, a review of this literature by Finkelhor (1990) found far more similarities than differences in the responses of abused males when

compared to abused females, on measures of such stress-related symptoms as anxiety, depression, aggression and somatic problems. Where differences existed, they were most often along the "internalizing" and "externalizing" dimensions, with males reported to more often act out aggressively, and females more often reported to act depressed (Finkelhor, 1990, p. 326; Friedrich, 1990, p. 60). Although the study of differential initial effects to trauma is in its infancy, some studies have reported sex differences in the post-traumatic stress reactions of children traumatized by sexual abuse (Kiser et al., 1988) and natural disaster (Burke et al., 1986). Males in these studies evidenced more intense reactions than females initially, which were progressively resolved over time. Females tended to retain their symptoms longer, and/or experienced a recurrence of symptoms at a later time. Interestingly, as cited by Carskadon (1979, p. 14), Van Dyne found that extraverted males reported the greatest vividness of mental imagery during hypnosis. Further research in this area might auger well for increased effectiveness of hypnosis with this population,

characterized by traumatized, extraverted, intuitive males.

Handedness amongst the subjects was found to have an interesting relationship to their receptivity. Practitioners evidenced slightly more receptivity if right-handed, while non-practitioners evidenced significantly more receptivity if left-handed. The trend appearing across both groups however, was for receptivity to increase with reported general use of both hands.

As summarized by Bradshaw and Nettleton (1981), evidence exists demonstrating the functional differences between the cerebral hemispheres in right-handed people: the left hemisphere displays an advantage for verbal and analytical thinking, while the right hemisphere is at an advantage for spatial and holistic processing. A study by Crossman and Polich (1989) further tied the preferred use of each hemisphere for verbal and spatial tasks to personality type. Their findings indicated that right-brain processing was predominantly true for individuals indicating intuitive (N) and perceptive (P) MBTI

preferences, with no gender differences. Similar evidence was found by Taggart et al. (1991) using a different measure of brain hemisphere dominance in the form of the Human Information Processing Survey (HIP-S), together with the Myers-Briggs Type Indicator.

If personality preference mirrors the predominant use of the right brain, and right-brain functioning is a major requirement of techniques like hypnosis, one would expect to find a greater and more uniform receptivity towards hypnosis within the more intuitive (N) practitioner group, regardless of individual hand preference, as was the case. This would not be true for the less intuitive, non-practitioner group, where more left-brain, analytical functioning would be the norm, itself reflective of a more sensing (S) orientation. It is hypothesized that trends, as appeared in our data, may be reflective of individuals who purposefully use their left hand, reflecting some degree of regular right-brain functioning. Following this logic, the more the left hand was used/preferred, the more likely that individual would be to possess positive attitudes about hypnosis.

MBTI Preference Strength

The strength of responding to the Myers-Briggs questions in our study bears mention, as normative comparisons (Table 6) indicate some variation. In our study, practitioners tended to respond with a higher percentage of clear and very clear responses to questions than did the norm, and than did non-practitioners. Also, the percentage of slight responses from practitioners was remarkably higher than the norm for the sensing (S) preference, by inference leaving a smaller number of possible practitioners reflecting strong sensing responses. This leaning away from sensing towards intuitiveness appears to translate to the relatively consistent picture for practitioners of increasing receptivity with increasing intuitiveness (see Figure 5).

Interestingly, the trend is basically the same for non-practitioners as well, except where subjects have indicated slight responses for sensing (S). This corresponds to the only decline in receptivity for non-practitioners. Of note as well is that the maximum level of receptivity is being shown by the strongly

intuitive non-practitioners, and not the practitioners as one might expect. Reasons for these two anomalies may relate to the relatively low number of subjects reflected in some of the non-practitioner groupings of Table 6 (eg. 1 sensing male, 3 judging males, 4 perceptive males, 6 intuitive males). Numbers are substantially larger in all of the practitioner groupings, and hence results more reliable. What could assist in further interpretation of the non-practitioner trend is a larger, more focused look at non-practitioners in general, and male non-practitioners in particular.

Judging/Perception (JP)

The original hypothesis suggesting that the perceptive (P) preference would have a greater representation amongst individuals more receptive to hypnosis met with mixed results. On the one hand, intuition (N) appeared to influence receptivity for the most part independent of any significant relationship with either P or J (see Figure 6). In fact, receptivity appeared actually higher overall in subjects evidencing

a J preference. The one area where a perceptive (P) preference resulted in receptivity similar to that of intuitive (N) subjects was for moderately sensing individuals. The only areas where increased P preference appeared moderately related to increased receptivity was amongst 2 sub-groups of practitioners, those falling into the "abused" and "other" categories. Closer examination of these groups, as evidenced in Figures 11 and 12, revealed that receptivity in both sub-groups was greatest when respondents were indicating only a slight preference for P. In other words, they evidenced the potential for a degree of flexibility between J and P preferences.

The effects of J and P preferences upon receptivity for sensing (S) subjects was dramatically different than that for intuitive (N) subjects. In fact at intermediate levels of S it was actually opposing (see Figure 6). From Figures 9 and 10 it can be seen that while the most receptive intuitive subjects evidenced only a slight P preference, the most receptive sensing subjects depicted the opposite, a strong P preference. One interpretation of these

FIGURE 9 MEAN RECEPTIVITY AT DIFFERENT LEVELS OF JP - SENSING SUBJECTS

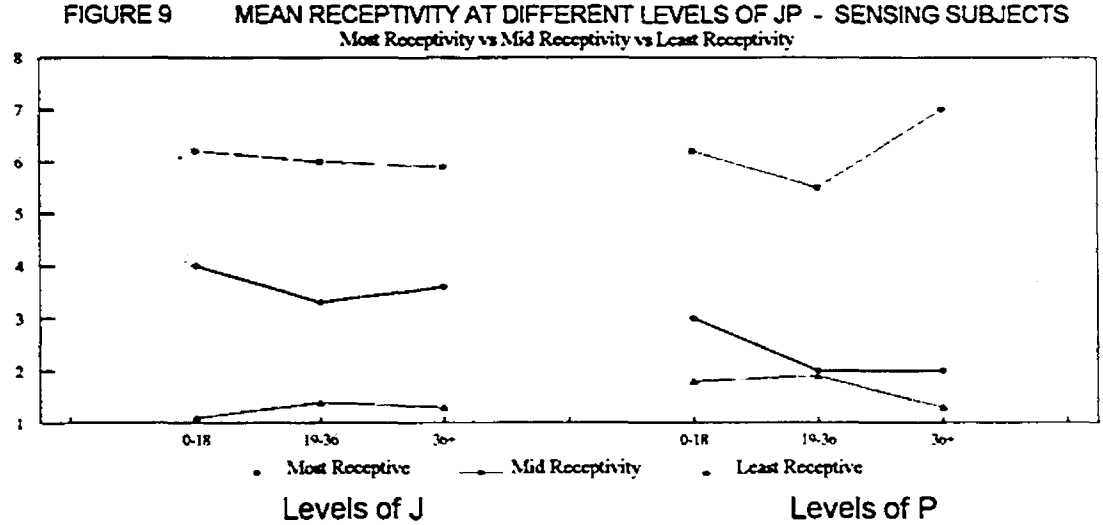


FIGURE 10 MEAN RECEPTIVITY AT DIFFERENT LEVELS OF JP - INTUITIVE SUBJECTS

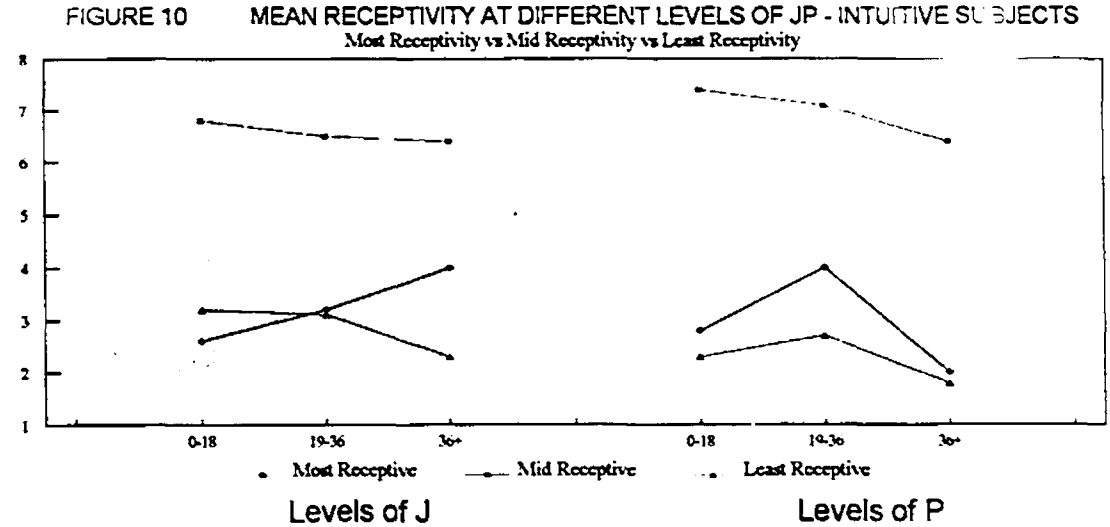


FIGURE 11 MEAN RECEPTIVITY AT DIFFERENT LEVELS OF JP - OTHER PRACTITIONERS

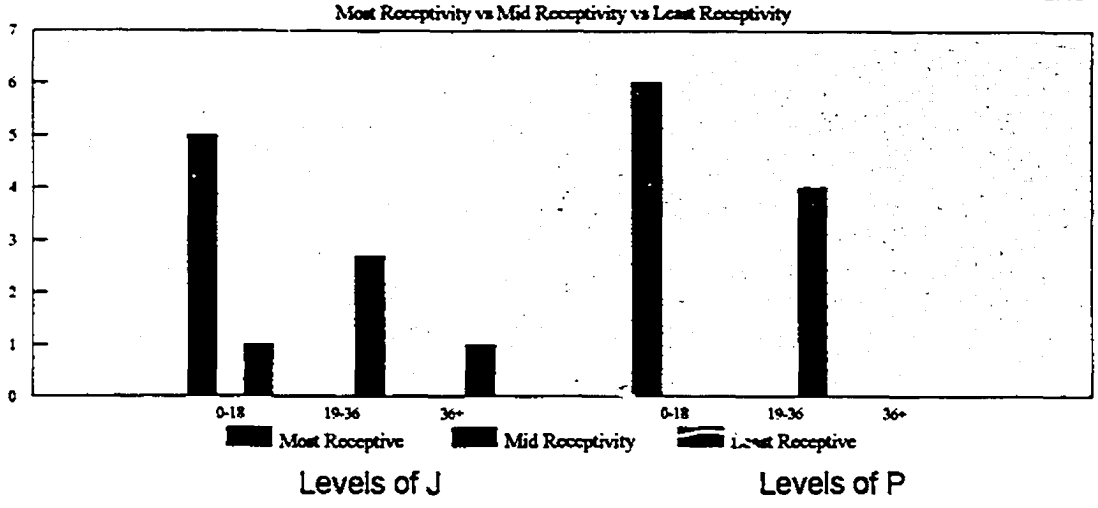
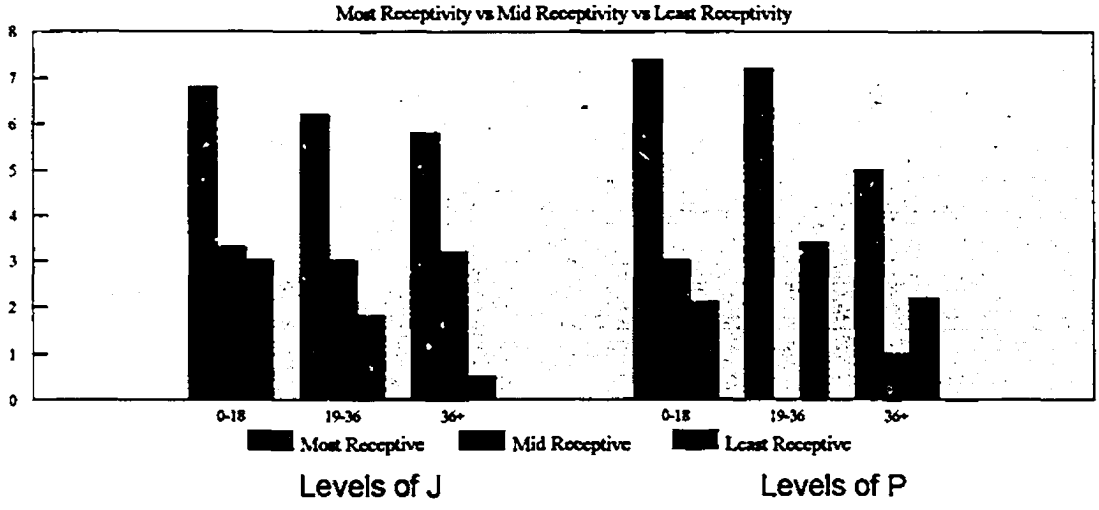


FIGURE 12 MEAN RECEPTIVITY AT DIFFERENT LEVELS OF JP - ABUSED PRACTITIONERS



findings is that in order to be most receptive to the more abstract idea of hypnosis, a stronger perceptive orientation to life is required by sensing individuals to offset or override their natural tendency to remain rooted in the concreteness of the here and now.

Receptivity Level

As depicted in Figure 7, the effects of SN on receptivity appeared quite consistent, regardless of whether individuals fell into low, mid or high receptivity groupings, with optimum receptivity appearing at moderate preference strength levels in all groupings except two (mid-receptive sensing and least-receptive intuitive). Since mid and high receptivity is characterized by experience with hypnosis, what these results appear to be indicating is that even without direct experience with hypnosis, intuitive subjects possessed a receptivity that came close to matching that of experienced subjects, whether sensing or intuitive. This was not the case for inexperienced sensing individuals, who evidenced notably less receptivity. Also, experienced sensing individuals at

the mid-receptivity level exhibited comparable receptivity to mid-receptive intuitives when sensing preferences were weakest. Finally, the most receptive sensing subjects, while certainly evidencing a level of receptivity higher than their sensing counterparts, did not reach the high receptivity levels of the most receptive intuitive subjects. In sum, intuitive subjects appeared both more open to hypnosis, even without direct experience with it, and tended to obtain more satisfactory results from hypnosis with experience. Figures 7A, 7B and 7C, which examined the same SN effects for practitioners, non-practitioners and abused subjects respectively, upheld the above findings. These results are somewhat reflective of a large and systematic study conducted by Bradway and Detloff, as cited by Carskadon (1979). In this study, practitioners in the form of Jungian analysts who possessed an intuitive (N) preference reported higher regard for a select number of therapies, hypnosis included.

The effects of hypnosis experience on the relationship between JP and receptivity, as illustrated

FIGURE 7A MEAN RECEPTIVITY AT DIFFERENT LEVELS OF SN - PRACTITIONERS

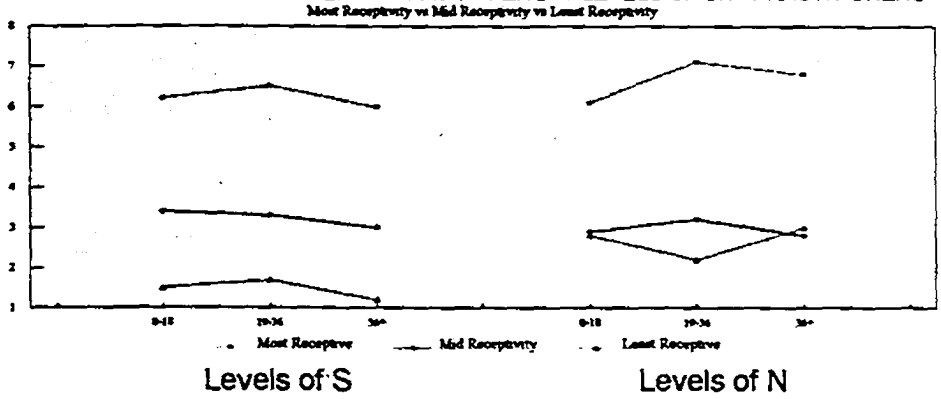


FIGURE 7B MEAN RECEPTIVITY AT DIFFERENT LEVELS OF SN - NON-PRACTITIONERS

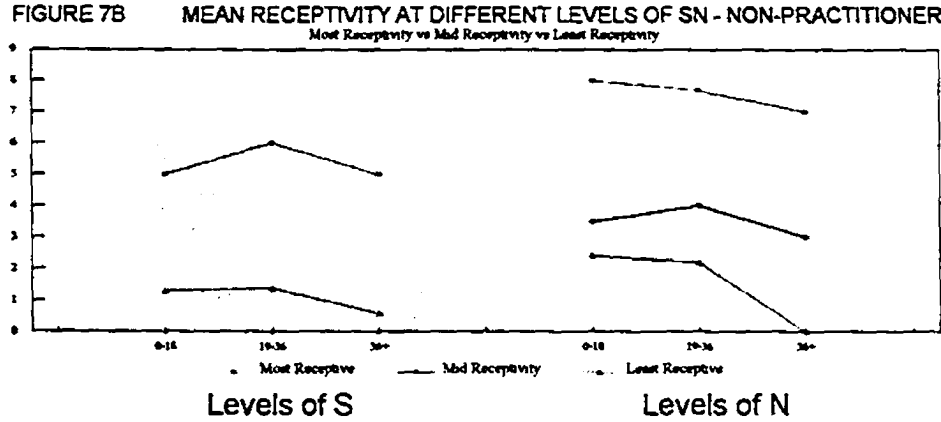
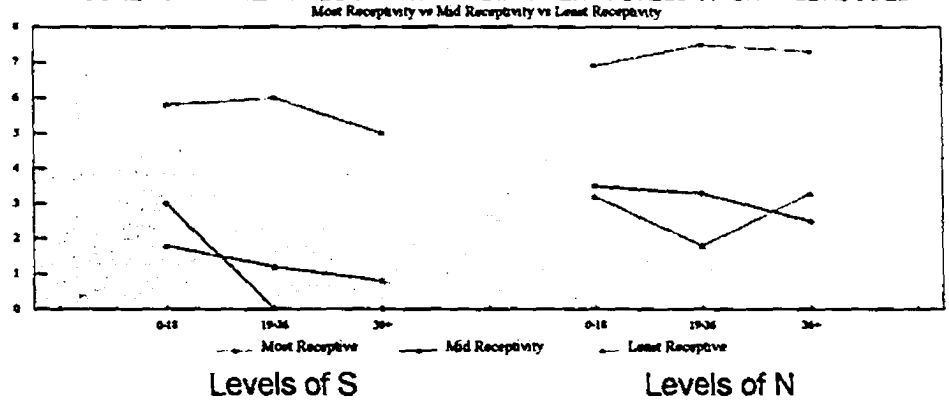


FIGURE 7C MEAN RECEPTIVITY AT DIFFERENT LEVELS OF SN - ALL ABUSED



in Figure 8, appeared different than that of the SN effects just discussed. For inexperienced subjects, maximum receptivity was evident in types where P was moderately preferred. In experienced subjects, J and P types responded differently at mid-receptivity levels, and then similarly at high receptivity levels. At mid-receptivity, it appeared that the receptivity of J types increased linearly as their J preference strengthened. For P types, a moderate P preference still indicated maximum receptivity, but appeared moving in the direction towards slight preference.

It could be interpreted from this that J types, characterized by their proclivity towards control, both of themselves and others to varying degrees are, at this level, responding to the technique of hypnosis from a control standpoint. The more they identify with the control potential of hypnosis, the more they may have experimented with it. However, satisfactory clinical results with hypnosis are based on empowerment of the client (E. Alexander, personal communication, 1993; J. Ferencz, personal communication, 1991 *), not on control by the practitioner. It would stand to

reason that a practitioner successful in the continuing use of hypnosis would reflect those same sentiments. On the other hand, the most receptive P types with experience, seem to be reflecting an increase in J attributes compared to the least receptive P's.

This discussion leads to a most interesting aspect, which is the picture that emerges at maximum levels of receptivity. The highest receptivity is evident in both J and P subjects when their preference strength is slight (ie. a subject is a P type, but only slightly so, or a subject is a J type, but only slightly so). What this may be implying is that maximum receptivity, comprised of positive attitudes about, beliefs in and experiences with hypnosis, is present in individuals who, by virtue of their slight JP preferences, are able to maintain a more flexible attitude in dealing with the world. This flexible attitude is more likely to embrace a technique like hypnosis, despite the lack of a well-established understanding of the mechanisms behind it, simply

* As stated by J. Ferencz PhD., C.Psych., M.D., speaking at Introductory Hypnosis Workshop sponsored by Ontario Society of Clinical Hypnosis Toronto, Ontario Nov. 1-3, 1991.

because of its apparent effectiveness.

In sum, it appears that possessing a slightly more perceptive (P) orientation is predictive of greatest receptivity in inexperienced individuals, and in highly receptive, experienced individuals. What would benefit from further analysis however, is distinguishing the differences between experienced individuals in the mid and high receptivity categories, since it is a judging (J) orientation that appears more predictive in this mid-receptivity range.

Abuse Statistics

This study, along with capturing data pertaining to hypnosis, has captured information relevant to the incidence of sexual abuse in one relatively broad Canadian population. Discussing this data in detail is beyond the mandate of this thesis, and as such it has been appended as supplementary information (see appendices H through J). However, comment will be made on one of the statistics captured, that being the prevalency rate of sexual abuse found amongst our subjects.

Reported sexual abuse prevalency rates vary, depending on the study under review. As cited by Steketee and Foa (1987, p. 69), rape is estimated to affect from 5% to 22% of adult women in the United States. A random sexual abuse survey conducted by Russell (1986), revealed that 38% of women in the United States experienced contact sexual abuse by an adult relative or stranger by age 18 years. Based on these and related findings, Russell estimated the prevalence of female sexual abuse in non-clinical populations to lie somewhere between 19 and 31%.

The abuse prevalency rate for males is even more ambiguous, with some researchers cited by Watkins and Bentovim (1992, p. 29) suggesting that males are abused in a ratio to females of 1:9, some estimating the abuse rate of males to be only slightly less than that of females, and others reporting ratios from clinical samples showing greater variation than this.

As reported in an article by Bayin (1993, p. 48), the estimate of female sexual abuse is considered "far too high" by some experts in the memory field. One of these experts, Dr. H. Lief, feels that a more accurate

figure would be closer to 8 to 10%. According to Lief, "what this means is that some of those claiming and sincerely believing they have been abused, haven't". As a result, many false accusations are levied, with much undue hardship resulting for innocent parties. Tragically, as Lief points out, "many falsely accused people are senior citizens who were looking forward to a pleasant retirement. Instead they are being hauled into court by their adult children, cut off from their grandchildren and paying a huge financial and emotional price".

Amongst the psychologists, physicians, counsellors and other practitioners surveyed in our study, abuse prevalency rates in their practices averaged 0-10% for males and 21-40% for females. Crisis centre counsellors, whose work centres almost exclusively around abuse victims, reported rates of 6% for males and 70% for females. Although our figures are similar to those of a number of others (Baker and Duncan, 1985; O'Neill and Gupta, 1991; Russell, 1986), some important considerations must be kept in mind in drawing comparisons. In the reporting of prevalency rates,

variations exist between studies in the definitions of sexual abuse, making uniform comparisons difficult and imprecise. Considering this, in this study it was decided to allow respondents unlimited freedom in their interpretation of their sexual abuse and subsequent responses to the questions regarding it, so as not to force elimination of responses in any manner. What resulted was that some respondents voluntarily identified possible ambiguities in their interpretation of sexual abuse. Also, it is one matter to operationally define sexual abuse and gather statistics in response to that definition, but another matter to interpret those statistics ignoring the effect (short and long term) of the abuse. What is traumatic to one individual may not be so to another, or not to the same extent. The scope of that interpretation was beyond the primary focus of this study.

Bearing in mind the cautionary comments regarding false recollections and accusations mentioned earlier, the proportion of actual sexual abuse reflected in any prevalency percentage is a moot question. But although the extent is highly debatable, just the possibility

itself of false memories points all the more to the importance of treatment approach in dealing with individuals reporting sexual abuse. In that sense, hypnosis becomes no more a technique of suggestion than any other therapeutic approach. It is really how a therapeutic approach is used by the clinician, and how well that approach matches the abilities of the client that matters.

Which is what this study has attempted to illuminate. Results from this comparatively large Canadian population found the intuitive (N) dimension of the Myers-Briggs Type Indicator to be predictive of receptivity to hypnosis. Generally, the perceptive (P) dimension appears to have its largest effect on the receptivity of inexperienced individuals, becoming less of an contributing factor with experience. Although data is retrospective and voluntary, with the inherent associated biases as a result, it represents a unique view of the sexual abuse issue, captured from the two perspectives of client and clinician simultaneously. Numerous possibilities for further study have already been mentioned, but a final one concerns high

receptivity. The focused examination of the group of individuals most receptive to hypnosis may uncover other insightful factors (eg. specific abuse characteristics, child punishment history, ego development, stress resiliency variables) related to their receptivity.

Thus far, the most salient aspects of the objective data captured in this study have been highlighted. However, it would be remiss to ignore the subjective component of the responses received. Almost one-quarter (24.7%) of responses reflected some type of respondent comment. Most of these concerned shades of meaning for questions comprising the Myers-Briggs Type Indicator. The others however, focused on the sexual abuse treatment questionnaire, and ranged from scathing criticism of the idea of yet another study, or "kick at the cat" being taken at the topic of sexual abuse, to enjoyment and appreciative "thank you's" for the opportunity to partake and express experiences, concerns and encouragement. A number of practitioners humbly acknowledged what they perceived as the power of hypnosis, and stressed the ethical aspect of healing -

the paramount importance of respecting the patient and his/her abilities, supports and readiness. The endorsement of hypnosis as an adjunct technique came across a number of times. Concerns regarding the possibility of false memory syndrome were expressed. No actual incidences related to it were conveyed. Two respondents highlighted how the mis-use of hypnosis in childhood had actually facilitated their abuse. One respondent reported knowledge of the mis-use of hypnosis by a male therapist.

All of these comments were unsolicited. Based on the relatively large number of them, belief is they are a good sign, and represent a healthy degree of genuine caring and concern within the health professions for the fine art of healing.

Given the apparent potential of hypnosis to heal or harm, it certainly behooves the clinical community to understand more about the practitioners who use it, and the individuals who benefit from it. The main findings of this study, those of the strong relationship between intuitiveness and receptivity to hypnosis, and the varying influence of a perceiving

attitude upon experience, is one step in that direction. As well, issues pertaining to "survivors" as a focal group, abused male non-practitioners, role of right-brain functioning, differential effects of perception on intuitive and sensing orientations, control in the mid-receptivity range, and highly-receptive individuals as a focal group have been raised. The pursuit of research in these areas will auger well for enhanced understanding of the treatment of sexual abuse with hypnosis.

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Appendix A

SEXUAL ABUSE TREATMENT SURVEY

Lakehead University
1993

A Survey of Ontario Practitioners and Survivors of Sexual Abuse

This survey is being used to study attitudes towards hypnosis, specifically in the treatment of sexual abuse. We are interested in finding out firstly about your experiences with sexual abuse, and secondly about your experiences with and attitude towards hypnosis. We hope the valuable information you provide can be used to assist practitioners and survivors alike in assessing the applicability of hypnosis as a therapeutic technique in the treatment of sexual abuse.

All of the information you provide will be kept in strictest confidence. We will not release any results in a manner in which you, or any other individual, can be identified. You are not required to indicate your name, address, or any other identifying information on the questionnaire. However, if you are interested in the results of this study in general, and/or your own results in particular, complete the mailing information on the last page of the questionnaire.

Note that there are **two parts** to this survey. It is very important that **both parts be completed.** The two parts consist of:

(1) yellow questionnaire - read each question carefully, and circle the appropriate response
- approx. time to complete is 10 minutes

(2) Myers-Briggs Type Indicator - read each question carefully, and circle the appropriate response
- approx. time to complete is 25 minutes

Thank you for taking the time to complete both the questionnaire and the personality inventory. Your prompt completion and return of both is greatly appreciated.

Please indicate which of the following applies to you. Circle your responses.
Note: More than one may apply.

I am a:

1. sexual abuse survivor
2. licensed psychologist
3. licensed physician
4. counsellor
5. other - (please specify) _____

I have:

1. experienced sexual abuse/assault as a child (age 0-16)
2. experienced sexual abuse/assault as an adult
3. not experienced sexual abuse/assault
4. treated/counselled survivors of sexual abuse
5. not treated/counselled survivors of sexual abuse

My abuse/assault took place at the hands of a (circle all that apply):

1. parent/step-parent/guardian
2. sibling (brother, sister, step-brother, step-sister)
3. aunt/uncle/grandparent/cousin
4. non-family member (10 years or more older than I)
5. non-family member (less than 10 years older than I)
6. babysitter
7. stranger
8. individual known to me
9. male
10. female

The abuse/assault episodes occurred:

1. 1 time
2. 1 to 10 times
3. 10 to 25 times
4. 25 to 50 times
5. more than 50 times
6. and is still occurring
7. uncertain

The abuse/assault episode(s) covered:

1. 1 day
2. 1 month
3. 1 year
4. 1 to 3 years
5. 3 to 6 years
6. 6 to 10 years
7. more than 10 years
8. uncertain

Age when abuse began: _____ years

Age when abuse ceased: _____ years

I am:

1. interested in hypnosis
2. interested in hypnosis and intend to learn more
3. not interested in hypnosis
4. not interested in hypnosis myself but see no problem if others use it
5. against the use of hypnosis

I have:

1. been hypnotized
2. not been hypnotized
3. been hypnotized as part of my treatment for sexual abuse
4. used hypnosis in treating/counselling others
5. used hypnosis in treating/counselling sexual abuse survivors

I believe hypnosis:

1. allows others to control me
2. is useful only for entertainment purposes (ie. stage hypnotist)
3. is a technique that allows me better control of myself
4. has many useful applications (ie. controlling pain)
5. has helped me overcome my abuse trauma
6. has had no effect on my abuse trauma
7. has had a negative effect on my abuse trauma

I have:

1. had experience using imagery/visualization techniques
2. found imagery/visualization easy to accomplish
3. used guided imagery to relax (visualizing peaceful scenes, listening to ocean, etc.)
4. found listening to music to be calming/relaxing
5. found imagery/visualization has helped me overcome my abuse trauma
6. found imagery/visualization has had no effect on my abuse trauma
7. found imagery/visualization has had a negative effect on my abuse trauma

If you are **not** a practitioner/counsellor, please **proceed to page 4.**

If you are a practitioner/counsellor, please continue.

In my practice, the approximate percentage of clients presenting with a history of sexual abuse is as follows:

Males		Females	
1.	0 - 10%	2.	0 - 10%
3.	11 - 20%	4.	11 - 20%
5.	21 - 40%	6.	21 - 40%
7.	41 - 60%	8.	41 - 60%
9.	61 - 80%	10.	61 - 80%
11.	81 - 100%	12.	81 - 100%

The therapeutic approach(es) I use in the treatment of sexual abuse is/are as follows (circle **all** that apply):

1. psychoanalysis
2. multi-modal therapy
3. family therapy
4. rational emotive therapy
5. stress inoculation (including imagery & visualization)
6. client-centered therapy
7. brief psychotherapy
8. hypnosis
9. behaviour modification
10. other (please specify _____)

On the following scales (1 = minimum effectiveness and 10 = maximum effectiveness), rate generally how effective you find **each of the therapeutic approaches you have circled above** to be:

1. min. 1...2...3...4...5...6...7...8...9...10 max.
2. min. 1...2...3...4...5...6...7...8...9...10 max.
3. min. 1...2...3...4...5...6...7...8...9...10 max.
4. min. 1...2...3...4...5...6...7...8...9...10 max.
5. min. 1...2...3...4...5...6...7...8...9...10 max.
6. min. 1...2...3...4...5...6...7...8...9...10 max.
7. min. 1...2...3...4...5...6...7...8...9...10 max.
8. min. 1...2...3...4...5...6...7...8...9...10 max.
9. min. 1...2...3...4...5...6...7...8...9...10 max.
10. min. 1...2...3...4...5...6...7...8...9...10 max.

Now we would like to ask you some information about yourself. Circle the appropriate response number, or fill in the blanks where required.

Gender: 1. male
2. female

Marital Status: 1. single
2. married/cohabit.
3. separ/div/widowed

Date of birth: _____/_____/_____
day month year

Which hand do you generally prefer to use?

1. right
2. left
3. both, with equal dexterity
4. both, with greater dexterity in the right hand
5. both, with greater dexterity in the left hand

In acquiring a new skill (ie. learning to play the piano), would you prefer to learn:

1. by observing, listening and imitating (ie. playing by ear)
2. by following instructions (ie. reading music)

How often are you able to recall your dreams?

1. daily
2. weekly (1 - 4 times per week)
3. monthly (1 - 4 times per month)
4. seldom (1 - 6 times per year)
5. very rarely (once every few years)
6. never

How often do you daydream/fantasize?

1. many times per day
2. at least once per day
3. 3 - 5 times per week
4. 3 - 5 times per month
5. less than once per month
6. less than once per year
7. never

Please circle either yes (Y) or no (N) in response to the following:

I understand the information given in this survey will be reported only in general terms, and my identity will be kept confidential. Y N

I am interested in obtaining a summary of the survey results, once they have been compiled. Y N

I am interested in obtaining an interpretation of my own personality. Y N

Complete the following if requesting results of this survey.
Note: If preservation of anonymity is desired, specify a mailing address other than your own.

Mailing address:

_____
_____
_____
_____

Once again, thank you very much for your participation. It is most welcome and appreciated!

Just a reminder..... If you have not already done so, please complete the Myers-Briggs Type Indicator (personality inventory) that is included in your survey package of material.

Appendix B

Myers-Briggs Type Indicator - Form G
Sample Items

DIRECTIONS

There are no "right" and "wrong" answers to these questions. Your answers will help show how you like to look at things and how you like to go about deciding things. Knowing your own preferences and learning about other people's can help you understand where your special strengths are, what kinds of work you might enjoy, and how people with different preferences can relate to each other and be valuable to society.

Note: With the knowledge of the publisher (Consulting Psychologists Press, Inc.), the following paragraphs of the directions were modified to allow respondents to answer directly on the question booklets, rather than using a separate answer sheet, as is standard practice. Respondents were also instructed to answer all questions.

Read each question carefully and **circle the letter** of the answer that best reflects your preference. Do not think too long about any question.

If you cannot decide on a question, skip it and return to it at the end. However, it is important that you answer all questions.

SAMPLE QUESTIONS

Part I: Which Answer Comes Closer to Telling How You Usually Feel or Act?

4. Do you prefer to
   (A) arrange dates, parties, etc., well in advance, or
   (B) be free to do whatever looks like fun when the time comes?

21. Do you usually
   (A) value sentiment more than logic, or
   (B) value logic more than sentiments?

Part II: Which Word in Each Pair Appeals to You More?

39. (A) systematic
   (B) casual

64. (A) quick
   (B) careful

Part III: Which Answer Comes Closer to Telling How You Usually Feel or Act?

79. Are you
   (A) easy to get to know, or
   (B) hard to get to know?

84. When you start a big project that is due in a week, do you
   (A) take time to list the separate things to be done and the order of doing them, or
   (B) plunge in?

Note: Illustrative directions and sample items are from the Myers-Briggs Type Indicator - Form G by Katherine C. Briggs and Isabel Briggs Myers, and are included in this publication with the written permission of Consulting Psychologists Press, Inc.

Appendix C

LAKEHEAD UNIVERSITY

955 Oliver Road, Thunder Bay, Ontario, Canada P7B 5E1

Department of Psychology
Telephone (807) 343-8441

Dear Participant:

Lakehead University of Thunder Bay Ontario, is conducting a survey of both practitioner and survivor attitudes with respect to the treatment of sexual abuse.

You have been selected to complete a questionnaire and personality inventory that will contribute to our understanding of clinically relevant factors valuable in the treatment of sexual abuse. Please understand that **your input is requested regardless of the extent of your experience in this area.** We are asking for your help by completing both the questionnaire and personality inventory. Completion of both should take approximately one half hour of your time, and we assure you that all information will be treated confidentially. At no time will your name be associated with your response. If you do not wish to answer any specific item, you are under no obligation to do so.

Should you choose to complete the survey material, it is important that you do so **in the next few days.** When you have completed both the questionnaire and the personality inventory, please return them to us in the self-addressed, stamped envelope through Canada Post.

Again, let me assure you that you will not be required to provide any identifying information on the survey material, and that all your responses will remain anonymous. At no time will anyone other than the research staff see the individual responses. If you desire a general summary of the survey results based on grouped statistics, and/or your own specific personality results, you may indicate so on the last page of the yellow questionnaire.

Please accept our sincere gratitude for participating in this important survey.

Yours very truly,

Marilyn L. Lylyk, M.A. candidate

Appendix D

LAKEHEAD UNIVERSITY

955 Oliver Road, Thunder Bay, Ontario, Canada P7B 5E1

Department of Psychology
Telephone (807) 343-8441

Dear Practitioner:

Lakehead University of Thunder Bay Ontario, is conducting a survey of both practitioner and survivor attitudes with respect to the treatment of sexual abuse.

You have been selected as a possible resource pool of survey participants. Using your own discretion, we would ask that you provide as many sexually-abused/assaulted clients and agency counsellors as possible with the opportunity of completing the accompanying questionnaire and personality inventory packages. It is hoped that the results of this research will contribute to our understanding of clinically relevant factors valuable in the treatment of sexual abuse. We are asking for your help in the following ways:

(1) by completing both the questionnaire and personality inventory yourself, and
(2) by providing approximately half of the survey packages to as many sexually-abused/assaulted clients as possible (male, female, adolescent and adult), and
(3) by providing the remaining survey packages to as many of your counselling personnel as possible.

Completion of an entire package should take approximately one-half hour of respondent time, and we assure you that all information will be treated confidentially. At no time will your name, or the names of your clients be associated with any of the responses. If the respondent does not wish to answer any specific item, there is no obligation to do so.

Should you choose to assist with this research effort, it is important for you to complete your survey material **in the next few days**. Packages for your clients/counsellors can be distributed when appropriate **over the next month**. I would like to have **all** responses back to the university **by March 15, 1994**, to permit the next stage of result analysis to begin. As packages are completed (both the questionnaire and the personality inventory), please have them returned to us in the self-addressed, stamped envelopes through Canada Post.

Again, let me assure you that neither your staff nor your clients will be required to provide any identifying information on the survey material, and that all responses will remain anonymous. At no time will anyone other than the research staff see the individual responses. If a general summary of the survey results

based on grouped statistics, and/or specific respondent personality results are desired, this may be indicated on the last page of the yellow questionnaire.

I would like to take this opportunity to sincerely thank you for your anticipated participation in this important research project. If you have any questions, or need clarification of any aspect of this project, please do not hesitate to contact me at (807) 622-9869 or (807) 343-4626.

Yours very truly,

Marilyn L. Lylyk, M.A. candidate

LAKEHEAD UNIVERSITY

955 Oliver Road, Thunder Bay, Ontario, Canada P7B 5E1

Department of Psychology
Telephone (807) 343-8441

Dear Practitioner:

Lakehead University of Thunder Bay Ontario, is conducting a survey of both practitioner and survivor attitudes with respect to the treatment of sexual abuse.

You have been selected as a possible resource pool of sexual abuse survivors who may be in various stages of treatment. Using your own discretion as to emotional stability, we would ask that you provide as many sexually-abused clients as possible with the opportunity of completing the accompanying questionnaire and personality inventory packages. It is hoped that the results of this research will contribute to our understanding of clinically relevant factors valuable in the treatment of sexual abuse. We are asking for your help in the following two ways:

(1) by completing both the questionnaire and personality inventory yourself (found in the envelope labelled with your name), and
(2) by providing the survey packages (labelled 'Survey Participant') to as many sexually-abused clients as possible (male, female, adolescent and adult).

Completion of the entire package should take approximately one-half hour of respondent time, and we assure you that all information will be treated confidentially. At no time will your name, or the names of your clients be associated with any of the responses. If the respondent does not wish to answer any specific item, there is no obligation to do so.

Should you choose to assist with this research effort, it is important for you to complete your survey material **in the next few days.** Packages for your clients can be distributed when appropriate **over the next month.** I would like to have **all** responses back to the university **by March 15, 1994,** to permit the next stage of result analysis to begin. As packages are completed (both the questionnaire and the personality inventory), please have them returned to us in the self-addressed, stamped envelopes through Canada Post.

Again, let me assure you that neither you nor your clients will be required to provide any identifying information on the survey material, and that all your responses will remain anonymous. At no time will anyone other than the research staff see the individual responses. If a general summary of the survey results based on

grouped statistics, and/or specific respondent personality results are desired, this may be indicated on the last page of the yellow questionnaire.

I would like to take this opportunity to sincerely thank you for your anticipated participation in this important research project. If you have any questions, or need clarification of any aspect of this project, please do not hesitate to contact me at (807) 622-9869 or (807) 343-4626.

Yours very truly,

Marilyn L. Lylyk, M.A. candidate

LAKEHEAD UNIVERSITY

955 Oliver Road, Thunder Bay, Ontario, Canada P7B 5E1

Department of Psychology
Telephone (807) 343-8441

Dear Practitioner:

Lakehead University of Thunder Bay Ontario, is conducting a survey of both practitioner and survivor attitudes with respect to the treatment of sexual abuse.

You have been selected as a possible resource pool of sexual abuse survivors who may be in various stages of treatment. Using your own discretion as to emotional stability, we would ask that you provide as many sexually-abused clients as possible with the opportunity of completing the accompanying questionnaire and personality inventory packages. It is hoped that the results of this research will contribute to our understanding of clinically relevant factors valuable in the treatment of sexual abuse. We are asking for your help in the following two ways:

(1) by completing both the questionnaire and personality inventory yourself (found in the envelope labelled with your name), and
(2) by providing the survey packages (labelled 'Survey Participant') to as many sexually-abused clients as possible (male, female, adolescent and adult).

Completion of the entire package should take approximately one-half hour of respondent time, and we assure you that all information will be treated confidentially. At no time will your name, or the names of your clients be associated with any of the responses. If the respondent does not wish to answer any specific item, there is no obligation to do so.

Should you choose to assist with this research effort, it is important for you to complete your survey material **in the next few days**. Packages for your clients can be distributed when appropriate **over the next two weeks.** I would like to have **all** responses back to the university **by April 15, 1994**, to permit the next stage of result analysis to begin. As packages are completed (both the questionnaire and the personality inventory), please have them returned to us in the self-addressed, stamped envelopes through Canada Post.

Again, let me assure you that neither you nor your clients will be required to provide any identifying information on the survey material, and that all your responses will remain anonymous. At no time will anyone other than the research staff see the individual responses. If a general summary of the survey results based on

grouped statistics, and/or specific respondent personality results are desired, this may be indicated on the last page of the yellow questionnaire.

I would like to take this opportunity to sincerely thank you for your anticipated participation in this important research project. If you have any questions, or need clarification of any aspect of this project, please do not hesitate to contact me at (807) 622-9869 or (807) 343-4626.

Yours very truly,

Marilyn L. Lylyk, M.A. candidate

Appendix E

Grouping Criteria for High, Mid and Low Receptivity

High and Mid-receptivity

In order to be categorized in either high or mid-receptivity groups, respondents require some type of personal experience with hypnosis. Additionally or alternatively, they may report having used hypnosis as a clinical approach to treating sexual abuse. Meeting the above criteria, if receptivity level exceeds 4.5, they are categorized in the high receptivity group. If receptivity level is 4.5 or less, they fall into the mid-receptivity grouping.

Computation

```
If (HYPEXP gt 0 or THERAP08 eq 1) and RECEPT gt 4.5
    HYPGRP = 1
If (HYPEXP gt 0 or THERAP08 eq 1) and RECEPT lt 4.5
    HYPGRP = 2
```

Note: Values for RECEPT can only be whole numbers, not fractional. Therefore, group 1 (high receptivity) actually reflects receptivity of 5 and up, while group 2 (mid-receptivity) reflects receptivity of 4 and less.

Lov Receptivity

Individuals not meeting the above criteria by default are categorized into the low receptivity grouping.

Appendix F

Mapping of Survey Questions to Receptivity Variables

Questions used to capture information concerning interests, beliefs and experiences in and with **hypnosis** are as follows:

VARIABLE NAME		
	I am:	
HYPPOS---	1.	interested in hypnosis
HYPPOS---	2.	interested in hypnosis and intend to learn more
HYPNEU---	3.	not interested in hypnosis
HYPPOS---	4.	not interested in hypnosis myself but see no problem if others use it
HYPNEG---	5.	against the use of hypnosis
	I have:	
HYPEXP---	1.	been hypnotized
HYPNEU---	2.	not been hypnotized
HYPEXP---	3.	been hypnotized as part of my treatment for sexual abuse
HYPEXP---	4.	used hypnosis in treating/counselling others
HYPEXP---	5.	used hypnosis in treating/counselling sexual abuse survivors
	I believe hypnosis:	
HYPNEG---	1.	allows others to control me
HYPNEU---	2.	is useful only for entertainment purposes (ie. stage hypnotist)
HYPPOS---	3.	is a technique that allows me better control of myself
HYPPOS---	4.	has many useful applications (ie. controlling pain)
HYPPOS---	5.	has helped me overcome my abuse trauma
HYPNEU---	6.	has had no effect on my abuse trauma
HYPNEG---	7.	has had a negative effect on my abuse trauma

Each endorsement (circling of a response) by the respondent was equated to a value of 1 (one). HYPNEG was an exception, in that endorsements were doubly weighted if the respondent also indicated experience with hypnosis. Responses were totalled according to their applicability for inclusion by the following variables:

HYPPOS = positive interest/belief in hypnosis

HYPEXP = experience with hypnosis on oneself and/or others
HYPNEU = neutral interest/belief/experience with hypnosis
HYPNEG = negative interest/belief/experience with hypnosis

Questions used to capture information concerning interests, beliefs and experiences in and with **imagery** are as follows:

VARIABLE NAME	I have:	
IMAGEXP--	1.	had experience using imagery/visualization techniques
	2.	found imagery/visualization easy to accomplish
IMAGEXP--	3.	used guided imagery to relax (visualizing peaceful scenes, listening to ocean, etc.)
	4.	found listening to music to be calming/relaxing
IMAGPOS--	5.	found imagery/visualization has helped me overcome my abuse trauma
IMAGNEU--	6.	found imagery/visualization has had no effect on my abuse trauma
IMAGNEG--	7.	found imagery/visualization has had a negative effect on my abuse trauma

Responses were totalled according to their applicability for inclusion by the following variables:
IMAGEXP = experience with imagery/visualization
IMAGPOS = positive belief in imagery/visualization
IMAGNEU = neutral belief in imagery/visualization
IMAGNEG = negative belief in imagery/visualization

Three types of receptivity were defined as follows:
HRECEPT - receptivity as measured by hypnosis questions alone
IRECEPT - receptivity as measured by imagery questions alone
RECEPT - overall receptivity as measured by both hypnosis and imagery questions

Computations for each definition of receptivity were as follows:

```
If HYPEXP gt 0 HYPNEG = (HYPNEG x 2)
Compute HRECEPT = (HYPPOS + HYPEXP) - HYPNEG
Compute IRECEPT = (IMAGPOS + IMAGEXP) - IMAGNEG
Compute RECEPT = (HYPPOS + HYPEXP + IMAGEXP + IMAGPOS) - (HYPNEG +
                 IMAGNEG)
```

Appendix G

Details of Responses for Male Non-Practitioners

Subj. No.	MB Type	Recept. Score	Abused	Abuse			
				Start Age (years)	Stop Age	Frequency	Duration
215	ENFJ	5.0	No				
226	INFJ	7.0	Yes	1	10	uncertain	
262	ESFP	5.0	Yes	6	10	1 time	uncertain
278	INFP	3.0	Yes	5	17	> 50	> 10 yrs
280	ENTJ	6.0	Yes	3	12	> 50	6-10 yrs
311	ENFP	9.0	Yes	4	7	uncertain	1-3 yrs
327	INFP	6.0	Yes	11	12	1-10	uncertain

Appendix H

TABLE 7

PRACTITIONER SUMMARY

(i) Prevalence of Sexual Abuse In Practice

	Psychologists Patients/Clients				Physicians Patients/Clients				Counsellors Patients/Clients				Other Practitioners Patients/Clients				All Practitioners Patients/Clients			
	Males		Females		Males		Females		Males		Females		Males		Females		Males		Females	
no response	9	(11%)	7	(9%) *	16	(12%)	10	(7%)	43	(67%)	3	(5%)	23	(46%)	11	(22%)	78	(27%)	27	(9%)
0-10%	51	(64%)	23	(29%)	100	(73%)	47	(34%)	15	(23%)	6	(9%)	20	(40%)	7	(14%)	164	(56%)	72	(25%)
11-20%	12	(15%)	12	(15%)	13	(10%)	34	(25%)	2	(3%)	3	(5%)	3	(6%)	4	(8%)	27	(9%)	47	(16%)
21-40%	5	(6%)	19	(24%)	4	(3%)	27	(20%)	0	(0%)	6	(9%)	1	(2%)	9	(18%)	9	(3%)	51	(18%)
41-60%	0	(0%)	11	(14%)	3	(2%)	10	(7%)	1	(2%)	5	(8%)	1	(2%)	1	(2%)	4	(1%)	26	(9%)
61-80%	3	(4%)	6	(8%)	0	(0%)	4	(3%)	1	(2%)	4	(6%)	0	(0%)	5	(10%)	4	(1%)	16	(6%)
81-100%	0	(0%)	2	(3%)	1	(1%)	5	(4%)	2	(3%)	37	(58%)	2	(4%)	13	(26%)	5	(2%)	52	(18%)
Average Prevalency		14%		25%		12%		21%		6%		70%		9%		21%		10%		36%

* Figures indicate the number and percentage of practitioners who encounter the listed rates of sexual abuse in the histories of their male and female patients/client For example, 7 (9%) means that 7 psychologists (or 9%) did not give an indication of the prevalence of sexual abuse amongst their female patients/clients.
Note: Percentage figures have been rounded.

(ii) Therapeutic Approaches Used In Treatment of Sexual Abuse

	Psychologists		Physicians		Counsellors		Other Practitioners		All Practitioners			
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Total	% of All Pract.
Psychoanalysis	2	5	10	8	2	5	4	3	12	19	31	10.7%
Multi-modal Therapy	9	18	21	32	2	16	3	8	31	64	95	32.6%
Family Therapy	6	11	12	23	4	8	3	5	19	41	60	20.6%
Rational Emotive Therapy	2	4	9	11	1	11	1	7	12	26	38	13.1%
Stress Inoculation	9	13	4	11	0	25	1	7	13	50	63	21.6%
Client-centered Therapy	9	16	15	25	4	34	3	16	26	77	103	35.4%
Brief Psychotherapy	9	11	31	38	2	7	3	11	42	58	100	34.4%
Hypnosis	6	6	8	10	2	2	0	5	15	19	34	11.7%
Behaviour Modification	5	5	6	11	3	19	2	11	13	37	50	17.2%
Other **	16	25	20	27	3	26	5	16	37	84	120	41.2%

** Other category includes the following therapeutic approaches: referral to specialized treatment facility, self-psychology/informed psychotherapy, PTSD "courage to heal" approach, long term therapeutic healing relationship, Ottobart Mowrer's integrity therapy, crisis counselling/support/advocacy, insight-oriented psychotherapy, cognitive therapy, psychodynamic, art therapy, systemic/strategic, psychosynthesis, experiential therapy, PTSD desensitiz'n, Frankl's logotherapy, supportive psychotherapy, women's support groups, object relations therapy, informal client education, psychopharmacology, empowerment therapy. feminist therapy, group treatment, ego state therapy, narrative therapy, psychodrama, play therapy, interpersonal psychotherapy, empathic listener, long term psychotherapy, Ericksonian solution-focused, client-directed therapy, guided imagery/desensitization, eclectic, existential, Gestalt, NLP, dream work, tran analysis,

(iii) Mean Effectiveness of Therapeutic Approach (1=min. 10=max.)

	Psychologists	Physicians	Counsellors	Other Practitioners	All Practitioners
Psychoanalysis	7.6	5.3	5.1	5.7	5.9
Multi-modal Therapy	6.5	6.4	5.9	4.3	6.3
Family Therapy	5.5	5.0	5.0	5.6	5.2
Rational Emotive Therapy	5.8	5.9	4.5	4.6	5.5
Stress Inoculation	5.7	5.1	6.8	6.0	6.0
Client-centered Therapy	6.7	5.5	7.3	6.4	6.5
Brief Psychotherapy	5.5	5.4	4.0	5.1	5.4
Hypnosis	7.0	6.1	3.5	6.6	6.2
Behaviour Modification	6.0	6.2	6.3	5.5	6.1
Other	8.0	5.3	7.2	5.9	6.0

Appendix I

TABLE 8

ABUSE SUMMARY (PART I)

(i) Developmental Stage(s)

When Sexual Abuse/Assault Occurred	Practitioners (N=291)		Non-Practitioners (N=57)		All Abuse "Survivors" ** (N=104)		Only Abuse "Survivors" ** (N=42)		All Subjects (N=348)	
	Males (N=103)	Females (N=188)	Males (N=7)	Females (N=50)	Males (N=11)	Females (N=93)	Males (N=5)	Females (N=37)	Males (N=110)	Females (N=238)
In childhood (age 0-18)	17 (17%)	38 (20%) *	6 (86%)	24 (48%)	10 (91%)	47 (50%)	5 (100%)	19 (51%)	23 (21%)	62 (26%)
In adulthood	4 (4%)	22 (12%)	0 (0%)	3 (6%)	1 (9%)	8 (9%)	0 (0%)	2 (6%)	4 (4%)	25 (11%)
both childhood & adulthood	0 (0%)	20 (11%)	0 (0%)	20 (40%)	0 (0%)	38 (41%)	0 (0%)	16 (43%)	0 (0%)	40 (17%)
Total Reporting Abuse	21 (21%)	80 (43%)	6 (86%)	47 (94%)	11 (100%)	93 (100%)	5 (100%)	37 (100%)	27 (25%)	127 (54%)

* Figures indicate the number and percentage of males and females within the five major groupings listed. For example, 38 (20%) means that 38 out of 188 female practitioners (or 20%) experienced sexual abuse/assault during childhood, and not at any other developmental stage.

** The "All Abuse Survivor" category reflects individuals who categorized themselves as an abuse "survivor", and may have also included themselves in another category (eg. physician). The "Only Abuse Survivor" category reflects individuals who endorsed only the "survivor" category.

(ii) Ages of Abused

	Practitioners		Non-Practitioners		All Abuse "Survivors"		Only Abuse "Survivors"		All Subjects	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
At Abuse Commencement										
average age	12.0 (N=20)	12.1 (N=74)	5.0 (N=6)	7.6 (N=43)	8.1 (N=11)	8.7 (N=86)	5.2 (N=5)	7.8 (N=35)	10.2 (N=26)	10.5 (N=117)
youngest age	4.0	<1.0	1.0	1.0	1.0	<1.0	1.0	1.0	1.0	<1.0
oldest age	38.0	35.0	11.0	26.0	38.0	35.0	11.0	26.0	38.0	35.0
preschool				2		2				2
under 1 year		1				1				1
age unknown		5		1		6		1		6
At Abuse Cessation										
average age	13.6 (N=20)	17.2 (N=74)	11.3 (N=6)	17.2 (N=45)	14.0 (N=11)	16.7 (N=90)	12.2 (N=5)	17.2 (N=36)	13.2 (N=26)	17.2 (N=119)
youngest age	6.0	3.0	7.0	6.0	7.0	3.0	10.0	6.0	6.0	3.0
oldest age	39.0	42.0	17.0	46.0	39.0	46.0	17.0	43.0	39.0	46.0
elementary school				1		1				1
puberty				1		1		1		1
age unknown		5				4				5

Appendix J

TABLE 9

ABUSE SUMMARY (PART II)

(i) Abuse/Assault Perpetrators

	Practitioners		Non-Practitioners		All Abuse "Survivors"		Only Abuse "Survivors"		All Subjects			
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Total	% of All Subjects
Parent/step-parent/guardian	1	16	3	21	4	35	2	15	4	37	41	11.8%
Sibling (brother, sister, step)	4	12	1	10	3	19	1	10	5	22	27	7.8%
Aunt/uncle/grandparent/cousin	3	21	3	28	4	46	2	22	6	49	55	15.8%
Non-family indiv. 10+ yrs older	5	34	1	10	2	34	1	8	6	44	50	14.4%
Non-family indiv. <10 yrs older	4	19	0	8	2	22	0	4	4	27	31	8.9%
Babysitter	2	2	0	4	0	6	0	1	2	6	8	2.3%
Stranger	6	26	0	7	2	17	0	6	6	33	39	11.2%
Individual known to respondent	9	40	1	20	2	44	1	13	10	60	70	20.2%
Male	16	69	1	37	6	77	1	28	17	106	123	35.4%
Female	2	9	0	8	0	16	0	5	2	17	19	5.5%

(ii) Frequency of Sexual Abuse/Assault

	Practitioners		Non-Practitioners		All Abuse "Survivors"		Only Abuse "Survivors"		All Subjects			
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Total	% of All Subjects
1 time	8	34	1	3	2	23	1	3	9	37	46	13.2%
1 to 10 times	9	32	1	9	2	26	1	8	10	41	51	14.7%
10 to 25 times	2	6	0	9	1	14	0	6	2	15	17	4.9%
25 to 50 times	1	7	0	5	1	9	0	3	1	12	13	3.7%
more than 50 times	1	6	2	8	3	13	2	7	3	14	17	4.9%
is still occurring	0	0	0	1	0	1	0	1	0	1	1	.3%
uncertain	1	14	3	18	4	28	2	15	4	32	36	10.4%

(iii) Duration of Sexual Abuse/Assault

	Practitioners		Non-Practitioners		All Abuse "Survivors"		Only Abuse "Survivors"		All Subjects			
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Total	% of All Subjects
1 day	11	36	0	4	2	25	0	4	11	40	51	14.6%
1 month	3	4	0	0	0	3	0	0	3	4	7	2.0%
1 year	3	3	0	3	1	5	0	2	3	6	9	2.6%
1 to 3 years	0	12	1	6	1	13	0	4	1	18	19	5.5%
3 to 6 years	2	8	0	5	1	10	0	4	2	13	15	4.3%
6 to 10 years	1	8	1	11	1	16	1	10	2	19	21	6.0%
more than 10 years	1	11	1	11	2	18	1	9	2	22	24	6.9%
uncertain	1	13	3	10	4	19	3	7	4	23	27	7.8%

Appendix K

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Office of the President
Telephone (807) 343-8200

12 November 1993

Ms. M. Lylyk
Department of Psychology
Lakehead University
THUNDER BAY, ONTARIO
P7B 5E1

Dear Ms. Lylyk:

Based on the recommendation of the Ethics Advisory Committee, I am pleased to grant ethical approval to your research project entitled: PERSONALITY AND HYPNOSIS AS VARIABLES IN THE TREATMENT OF SEXUAL ABUSE.

Best wishes for a successful research project.

Sincerely,

ROBERT G. ROSEHART
President

/lw

cc: Dr. W. Melnyk