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Imagery Rescripting and Incest: Therapist Dialogue and Contextual Unique Change in Women Clients with Post-Traumatic Stress

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IMAGERY RESCRIPTING AND INCEST: THERAPIST DIALOGUE AND CONTEXTUAL UNIQUE CHANGE IN WOMEN CLIENTS WITH POST-TRAUMATIC STRESS

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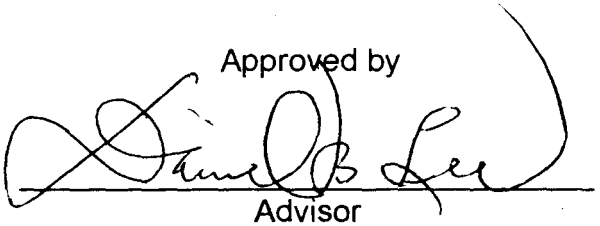

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Abstract

The prevalence of post-traumatic stress disorder (PTSD) among adult survivors of incest, in the context of a victimizing culture and health care reform in the United States, indicates a need for clinically effective and cost-effective therapeutic interventions. This study was designed to explore and evaluate one such treatment: Imagery Rescripting. Using content analysis of selected transcribed video-tapes of all therapy phases demonstrated a positive relationship between Imagery Rescripting and effective emotional processing of traumatic incest. Both quantitative and qualitative methods confirmed Imagery Rescripting's cost-effectiveness and clinical efficacy. Recommendations do include the suggestion for more specificity of client type and matching interventions, which can then produce even greater clinical and economic success. This study continued the social work legacy of evaluative practice and contextual client perspective in addressing serious social problems, such as incest.

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Sisters Marquerite Mc Gee, O.P. Roserita Kimmel, O.P. and Clarice Sevegney, O.P. My sincere gratitude for journeying with me in love, faith and trust during this four-year process. Sister Mary, especially, has been my consistent mainstay and she has sacrificed much during my years in Loyola's doctoral program.

DEDICATION

To my Sisters in Religious Community
who are committed to TRUTH
and compelled to JUSTICE
in our church and society

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CHAPTER I

NATURE AND SCOPE OF THE STUDY

"Tonight I stand before you an incest survivor. A list of all my accomplishments, pales before the most significant of all: I survived incest."

– *Marilyn Van Derbur Atler*
Miss America, 1958

INTRODUCTION

As a result of feminist-consciousness raising, the serious social problem of *incest* sparked the evolution of this study. In fact, girls appear to be especially vulnerable to incest; in a probability survey of over 900 women in California, Russell (1986) found that 16% had been sexually abused by a relative, and 4.5% reported sexual abuse by a father or stepfather before age 18. A recent nation-wide study of over 1,000 women in the Netherlands indicated almost identical findings: Fifteen percent of the sample reported sexual abuse by a relative in childhood (Draijer, 1988). Unfortunately, Judith Herman (1992) says that the vast majority of incest cases are undisclosed and undetected.

The short and long-term impact of incest on adult survivors has been well documented in the literature in recent years. Clinical symptoms often cited include chronic depression, anxiety and suicidality, self-destructive behaviors, and panic disorders, and post-traumatic stress disorder (Briere, 1989, 1992; Finkelhor, Hotaling, Lewis and Smith, 1989; Russell, 1986). In addition, feelings of guilt, self-disgust, self-blame, self-hatred, low-self esteem, powerlessness, mistrust of others, and a sense of despair (Briere and Runtz, 1992; Browne and Finkelhor, 1986; Herman, 1992; Smucker, Dancu, Foa and Niederee, 1996) result from traumatic incest.

Also in the **context** of managed health care in the United States today, there is a trend to match very specific problems with very specific effective treatment interventions which are cost-effective. This research was designed to respond to the prevalence (96% - 100%) of post-traumatic stress disorder (PTSD) in female adult survivors of incest with specific interventions to ameliorate the debilitating symptoms of PTSD and change, abuse-related beliefs and schemas. One such treatment model is **Imagery Rescripting** which is based on an expanded information processing model and conceptualizes the client's recurring traumatic memories within a PTSD framework and as part of the client's core schemata (Smucker, M. and Niederee, J., 1995).

A basic principle of information processing conceptualizations is that PTSD arises when a person is unable to adequately process a traumatic event, and that post-traumatic symptoms cease, once adequate processing has occurred. If, as a number of authors have asserted (Foa, and Kozak, 1986; Horowitz, 1979, 1986; Keane et al, 1985), PTSD results from inadequate emotional processing of traumatic events – and not essentially from the events themselves – then, should **not facilitating effective processing** be the goal of psychotherapy with this population?

Since Smucker et al (1993; 1995; and 1996) propose that Imagery Rescripting, indeed, does effectively process traumatic events of adult survivors of incest, it was logical to explore and evaluate Imagery Rescripting in this regard, with this population.

And the role, knowledge and skill of the therapist as exemplified in therapeutic dialogue was examined as a link to the theoretical assumptions of Imagery Rescripting and the occurring unique client change. In addition, Saari (1985) states that in the therapeutic process, the client/worker relationship is central to the achievement of any therapeutic result. Therefore, in psychotherapy, the **therapist and client create a context** for the unique client issues to emerge and be resolved.

Since women are more vulnerable to abuse in our culture, investigating the experience of women incest survivors in therapy and their accompanying change, will have significant benefit for clinical social workers. The study's examination of practical and scientific treatment interventions for survivors of incest-related PTSD will contribute to clinical knowledge and training, especially in social work and provide practice implications for clinicians, facilitate recovery of the victims of abuse at an affordable cost, and impact social change.

Statement of the Research Problem

Clinical social workers are concerned with developing and implementing clinically effective and cost-effective treatment interventions in order to facilitate the change process desired by the client within their "situation." This research investigated and evaluated the following:

(a) the relationship between Imagery Rescripting therapy and effective emotional processing of traumatic incest with adult women survivors;

(b) the specific interventions of Imagery Rescripting and the concurrent client variables as they relate to change;

(c) the structure of the variance in the therapist's dialogue across clients and across phases of therapy;

(d) the therapist structure as a connector to the theory of Imagery Rescripting and its sequence; and

(e) while being consistent with the treatment model, the therapist's demonstration of client and sequence similarities, as well as, adjustment to client differences and sequence differences.

There have been no **process studies** of Imagery Rescripting therapy, using both quantitative and qualitative methods with this targeted population. The state of knowledge in this area is limited to one published (Niedere, 1995) case study of incest-related schemas of powerlessness, abandonment, and mistrust changed to a sense of personal empowerment and self-actualizing.

This research, in a socioeconomic-political context which incorporates an analysis of both therapist/client dialogue and an evaluative inquiry of Imagery Rescripting from a quantitative and qualitative perspective, contributes to filling this gap in the literature.

Purpose of the Study

The purpose of this study was to examine the relationship between Imagery Rescripting and incest with women who live in a violent culture

specifically in the United States and who present in therapy with a diagnosis of post-traumatic stress disorder. This relationship was viewed from several perspectives in order to define and broaden social work's understanding of the therapist role, the unique client survivor, and the change process, both in a therapeutic and societal context.

Rationale

There is a special need for further treatment process/outcome research with particular types of traumatized adult clients such as intrafamilial sexual abuse; and examination of differential diagnosis and specific tailored treatments. First, social work practitioners will benefit from increasing their understanding of abuse-focused therapy in the therapeutic process; second, the needs and strengths of women clients are recognized from this research; third, treatment procedures can be developed and enhanced which take into account new insights and findings about incest's impact on the family, culture, survivor, and the psychotherapy process/outcome.

This research will add to the limited process studies in general, and with Imagery Rescripting in particular.

This research reinforces Waites' approach (1993) to dissociation and post-traumatic syndromes as normal reactions of women to trauma and victimization, both within the family and wider cultural context.

These findings are important to social workers who are engaged in policy-making, social change, conducting psychotherapy, and training social workers in the field.

From studying client incest experiences and Imagery Rescripting experiences, the researcher can formulate new questions that can generate even more specific interventions for particular incest client types and greater economic benefit for the provider, client and ultimately, society.

Definition of Major Concepts

The major concepts in the study are incest, post-traumatic stress disorder (PTSD), Imagery Rescripting therapy, interactional therapist structure, schemas, clinical effectiveness, cost-effectiveness, trauma, dissociation and change.

Incest is defined according to Dennis Gourley (1995, p.2) and Susanna Sgroi (1982, p.10) as the sexual use of a child by an adult who is over 15 years of age and at least five years the child's senior, in a kinship role/parent, step-parent, foster parent, grand-parent, uncle, aunt, cousin or sibling) in the same family group. Intrafamilial is not limited to

consanguineous relations. Sexual use includes consensual and nonconsensual behaviors intended for the sexual gratification of the adult, and is not limited to physical sexual contact.

Post-traumatic stress disorder (PTSD) refers to specific psychological reactions which may occur as a result of war, disaster, interpersonal violence or other forms of extreme psychological stress. In this study PTSD is defined according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV, 1994) as a combination of features from four core criteria which comprise the PTSD syndrome:

(1) exposure to a traumatic event

(2) reexperiencing of the trauma in recurrent memories, dreams, flashbacks, or heightened physiological reactivity

(3) emotional numbing or continued avoidance of stimuli connected to the event

(4) symptoms of increased arousal such as, exaggerated startle response, irritability, sleep disturbance and hypervigilence.

Imagery Rescripting therapy is defined as an imagery treatment using cognitive-behavioral procedures which are designed to alleviate post-traumatic stress disorder (PTSD) symptoms and change abuse-related

beliefs and schemas (e.g. powerlessness, self-hatred and guilt) of sexual abuse survivors and specifically in this study, female adult incest survivors (Smucker, M. and Niederee, J., 1994; Niederee, 1995).

Imagery Rescripting therapy will be further developed in the literature review in Chapter II and throughout the remaining study.

Interactional therapist structure is partially defined according to Czogalik's former research (1989) as simultaneously assessing many dimensions of the therapist verbal behavior in order to capture the general participating structures of therapeutic discourse. These multidimensional styles of participation are conceived as observable behavioral patterns (i.e., as stable and repetitive patterns of discourse that can vary **quantitatively**, depending on intentional and situational cues. Such quantitative variations are not expected to be random but to create meaningful patterns of participation over time. These patterns can also vary **qualitatively** according to therapeutic context; and therapist, as well as, client variables.

Schemas are defined generally as beliefs, expectations and assumptions about self and others (Mc Cann, and Pearlman, 1990).

Clinical **effectiveness** or clincial efficacy is generally defined according to the social work dictionary (Barker, 1995) as the degree to

which desired clinical goals or projected outcomes are achieved. Specifically in social work, the capacity to help the client achieve, in a reasonable time period, the goals of a given intervention.

Cost-effectiveness is defined as quality treatment for a specific problem at an affordable price.

Trauma is defined as a response or reaction to emotional injury rather than a course of illness. Therefore, developed further, trauma is a result of the complex relationship between an event and a person's perception of and reaction to that event (Everstine, D. and Everstine, L., 1993).

Dissociation is defined as cognitive separation of an individual from her environment at times of stress. For example, "Spacing out." (Briere, 1993).

Change is defined as quantitative change (e.g. the rate behavior A decreases in the course of therapy); qualitative or quantistructural change (e.g. the pattern between behaviors A, B, and C changes in the course of therapy); change in complexity and change as differentiation (Czogalik and Russell, 1994).

Research Questions

This study examined five research questions. Each question was addressed using quantitative or qualitative methods and the findings are presented in Chapter IV. The research hypotheses, necessary for data analysis, are stated in Chapter III.

(1) What is the relationship between Imagery Rescripting therapy and effective emotional processing of traumatic incest with adult female survivors?

(2) If there is a positive relationship in research question (1) What were the major specific treatment interventions?

(3) What is the structure of the therapist's dialogue and how consistent is it across clients and phases of therapy?

(4) How does the resultant structure link therapist participation and Imagery Rescripting 's theoretical assumptions and intended sequence?

(5) While being consistent with the treatment model, what are the client and sequence similarities, and how does the therapist participation adjust to client differences and across phases of therapy?

Research Plan

The plan designed to address these questions used both **quantitative and qualitative** research methods. Specifically, the design chosen was a **multivariate, replicated case study**, with **repeated measures** and **P-technique factor analysis** (see Chapter III for further explanation). This allowed the researcher to categorize and describe ideas and themes from transcripts of the videotaped selections of the course of therapy. In addition, the researcher quantified and analyzed some patterns of systematic change, for each individual studied. Then, the factor patterns of the therapist's structure could be compared quantitatively across clients and phases of therapy and analyzed qualitatively. The design incorporated a process approach, an evaluative inquiry and a feminist social work perspective.

Significance for Clinical Social Work

Clinical social workers continually seek practical, new methods and strategies to assist their clients in meeting their goals. Clients who have been sexually abused in childhood, frequently present with post-traumatic stress in post-abuse therapy. This study is relevant for clinical social workers because of their historical commitment to enhancing the quality of

the therapeutic relationship (Garrett, 1949; Hollis, 1964; and Perlman, 1979), as well as developing interventions which help the client problems and situation.

Further, there is a need for clinical social workers to become more involved in practice research as long ago, Mary Richmond (1922), did evaluative research about practice in order to facilitate lasting change and contribute to knowledge. The questions for this study were generated from practice, as well as prior research and it is anticipated that the findings will enrich other practitioners and stimulate further practice research.

Finally, since more women than men, as noted earlier in the introduction, have been known to be sexually abused in childhood, it was relevant to focus on this group and their issues, thereby enhancing social work's objective of empowering clients. Also an emphasis on environmental socioeconomic-political influences in developing post-traumatic stress and the need for affordable therapy has been recognized and requires further study. The findings for this study have been drawn from the therapeutic process, including the clients, hence validating a social work value which acknowledges the uniqueness and dignity of each individual. In true social work tradition, clients have always had much to teach us (Maluccio, 1979).

Assumptions of the Study

This study is built on the assumption that findings about Imagery Rescripting therapy and incest-related PTSD in women will have usefulness in clinical social work practice, education, policy and research.

The effort further assumes that the therapist and client will become more aware of the importance of the client and therapist context in the healing process of survivors.

The pertinence of the study's research techniques and methodology demonstrate the selection of "cutting-edge" approaches grounded in theory (e.g. process research; P-technique factor analysis; analysis of therapeutic interactive dialogue; multivariate, replicated case studies using repeated measures and Stuttgart Interactive Cateogry System/2). This combination of research techniques, some complicated and more sophisticated techniques; can be a greater bridge between research, practice and education in social work, as well as other disciplines.

Limitations of the Study

The limitations of the study are the following: a selective, retrospective, small sample; two coders (in contrast to three); the selection of the particular population; the use of the researcher as one of the coders;

and the lack of client demographics, except from the content of the therapeutic text and brief therapist forms; the lack of a published code book on the Stuttgart Interactional Category System/2; and the lack of the published clinical pilot outcome research on the Imagery Rescripting treatment model.

Summary

With incest as one of the serious social problems and the high prevalance of post-traumatic stress disorder among survivors, in the United State's context of a victimizing culture and the ongoing health care reform, the specific treatment response of Imagery Rescripting as a clinically effective and affordable treatment with this population was investigated and evaluated.

The clinical outcome pilot study of Imagery Rescripting (1993), according to Dr. Smucker (1996) was favorable to this treatment, although not definitive. To date, Dr. Smucker (psychologist and originator of Imagery Rescripting) claims their outcome study is the only one of its kind which assesses the clinical efficacy of this treatment with adult survivors of incest-related PTSD. However, the lack of more data from this unpublished study, was a limitation for myself as a researcher doing an evaluation of the model of Imagery Rescripting.

Since no process studies of Imagery Rescripting, using both quantitative and qualitative methods with the targeted population have been done, this research project will fill this gap in the empirical literature.

The study's intent was to understand and evaluate each of the major components of Imagery Rescripting with each corresponding client variable of change. The structure of the therapist's verbal interaction and the consistency of it across clients and thirds of therapy was examined. The role, knowledge and skill of the therapist, as exemplified in the therapist's interactive dialogue, was studied as a link to theoretical assumptions of Imagery Rescripting and client change.

The therapeutic context of the client/worker relationship, central to achievement of any therapeutic result, was likewise investigated.

Since women are more vulnerable to abuse in our United States culture, this study incorporated the women clients' experiences and their change with the use of Imagery Rescripting.

This study made some important suggestions to contribute to clinical knowledge, training, clinical practice and research especially within the social work discipline.

Finally, in the context of our socio-economic political environment, the truth about incest and victimization and the clinically effective recovery of victimized women at an affordable cost can impact societal change. There has

been a need in the clinical social work field for continuing practice-focused research to build ongoing theory and inform practice. This study values the voice and experience of the female client incest survivors as rich sources of data in combination with the therapist's participation, for building the treatment, research, and sexual abuse literature.

CHAPTER II

REVIEW OF THE LITERATURE

"In the imagery, I felt a feeling because I felt someone holding my hand. I've been able to get back into my body. Usually I'm not in my body when I have a memory."

– *Imagery Therapy, 1992*

Introduction

This chapter provides a context for understanding the historical developments in the field of **traumatic stress** studies, as well as, a synthesis of research and theoretical perspectives related to the consequences of victimization. First there is review of the data on the incidence and prevalence of various types of victimizing events. Then, there is a review of the historical evolution of viewpoints about post-trauma reactions, as well as some discussion on current definitions of post-traumatic stress disorder. Finally, this section reviews current pertinent theories of post-traumatic stress disorder and their relevance to **Imagery**

Rescripting therapy with an emphasis on the **incest survivor** in the context of her **family**, **society** and **therapeutic context**.

The Incidence and Prevalence of Victimization

As noted in Chapter I, the converging evidence of the incidence and prevalence of violence and other traumas experienced by persons suggests that victimization, especially of women and others with less power, is a pressing concern for social workers, as well as other mental health professionals. The data indicate that a significant proportion of people has experienced an event or series of events that can be considered to be traumatic at some point in their lives. Here is a presentation of a summary of these data as a way of providing a societal context for this topic area.

Child Abuse

The data on child sexual and physical abuse suggest that an overwhelming number of children, especially girl children, are subjected to trauma by adults who are entrusted, with their care. With regard to child physical abuse, approximately 1.4 million American children from the ages

of 3 to 17 experience acts of violence perpetrated against them by family members (Gelles and Cornell, 1985). According to Mc Cann and Pearlman, (1990), the most methodologically sound research in this area has been by Gelles, (1978); Gelles and Cornell, (1985); and Straus, Gelles, and Steinmetz (1980). In their study of family violence in a nationally representative sample of 2,146 individual family members, Straus et al. (1980) found that 3% of parents admitted to kicking, biting, or punching their children, and 1% reported beating their children at least once over the previous year. In a replicated study with 3,520 families, Straus and Gelles (1986) found a 47% lower incidence of child abuse. The authors speculate this might be due to different parental methods, increased reluctance to report, or actual decreases in child abuse. Despite these puzzling findings, the authors point out that even such a reduction would mean that still at least one million children each year are victims of physical abuse. Also, the complexities inherent in obtaining accurate data on the incidence of child abuse continue to pose a challenge for researchers.

Regarding childhood sexual abuse, Herman (1981) analyzed data from five surveys reported since the 1940s and found that 20% to 30% of adult women reported an unwanted sexual encounter with an adult male in

childhood. In more recent years, Russell (1984) conducted an interview study of sexual victimization in San Francisco. These data showed that 16% of women reported at least one incident of sexual abuse by a blood relative, while 31% reported at least one incident of sexual abuse by a nonrelative in childhood. Combining these two categories, Russell found that 38% of adult women reported at least one incident of incestuous or extrafamilial sexual abuse in childhood. Russell defined extrafamilial child sexual abuse as . . .

> One or more unwanted sexual experiences with persons unrelated by blood or marriage . . . before the victim turned 14 years, and completed or attempted forcible rape experiences from ages 14 to 17 years (inclusive), (Russell, 1984, pp. 180)

She defined incestuous child abuse as . . .

> Any kind of exploitative sexual contact or attempted sexual contact, that occurred between relatives, no matter how distant the relationship, before the victim turned 18, (Russell, 1984, pp. 181).

Young women with stepfathers are particularly vulnerable to being abused (17% rate for women with stepfathers versus 2% with biological fathers) (Russell, 1984). Russell's findings are consistent with Herman (1981), as well as with another national random sample in which 27% of

women reported that they experienced at least one incident of childhood sexual abuse (San Francisco. Chronicle, 1985). These latter figures are somewhat lower than in the Russell sample, perhaps because the interviews were done on the phone in contrast to the in-depth face-to-face interviews conducted by Russell.

Other Crime

The findings on criminal victimization suggest that crime has been on the rise in America since the mid-1970s. In 1984, approximately 37 million Americans experienced a criminal victimization (Herrington, 1985). Of these, 6 million were victims of a violent crime. The family violence research conducted by Straus et al (1980) showed that 16% of spouses reported violence between them during the year of the survey, while 28% reported acts of violence at some point in the marriage. Nearly four percent of the women were subjected to severe violence. A projection of these rates would suggest that 1.8 million women are victims of family violence each year.

Another serious criminal victimization is rape. In a random sample of 930 women, Russell (1984) found that 24% reported at least one rape over their lifetime, while 31% reported being a victim of an attempted rape. With

regard to marital rape, 14% of the married women reported a sexual assault by their husbands. In another national sample of 3,187 college women, Koss, Gidycz, and Wisniewski (1987) found that 27.5% reported being a victim of a rape or attempted rape. Nearly eight percent of college men reported a rape or attempted rape. Actually, none of these victims were involved in the criminal justice system.

These findings were also confirmed by Russell (1984). These data underscore the significant problem of underreporting of rape and other types of sexual victimization.

National Disasters

In a study that analyzed data regarding natural disasters, Gleser, Green, and Winget (1981) found that 836 major disasters involving over 100 deaths or injuries had occurred worldwide from 1947 through 1973. For example, the Armenian earthquake in the Soviet Union recently, is one instance of a widespread disaster which is likely to impact the lives of many for many years to come.

War and Genocide

The largest scale victimizations have resulted from war, with genocide being the most horrifying result of war. The Vietnam war is perhaps the most recent event in U.S. history which still continues to affect about 800,000 Vietnam veterans and their families. Among the victims of war in Southeast Asia, the genocide of the Cambodians during the Pol Pot regime was responsible for two million deaths. Since 1975, more than 700,000 refugees from Southeast Asia have settled in the United States, many with histories of severe trauma including torture (Mollica, Wyshak and La Velle, 1987).

Regarding the Nazi Holocaust, Danieli (1985) summarizes data which suggest that among the 8,861,000 Jews living in pre-World War II Europe, only a small percentage escaped.

Overall, these data suggest that the field of traumatic stress should be a focus for social workers and other mental health professionals working in a variety of settings. Even those professionals who choose not to specialize in this field, should become knowledgeable about traumatic stress because of the strong likelihood that they will be working with some clients who have been victimized.

Psychological Effects of Victimization

The literature on psychological reactions to victimization contains a variety of response patterns among victimized populations. The official classification of post-traumatic reactions is represented in the diagnostic criteria for post-traumatic stress disorder (PTSD). This category was first defined in DSM-III (American Psychiatric Association, 1980), and then revised in DSM -IIIR (American Psychiatric Association, 1987). The revised criteria for PTSD reflect changes because of the criticism that DSM-III criteria were biased toward reexperienceing, rather than denial symptoms (see Brett, Spitzer, and Williams, 1988, for a discussion of these changes). In the **four proposed diagnostic definitions** of stress disorders of DSM-IV criteria, it is critical to adopt a life-span perspective of PTSD. (For a specific discussion of the DSM definitions of stress disorders, see Meichenbaum, 1994 and for the specific definition of PTSD used in this study, see the section on definitions).

The criteria for PTSD continue to be controversial for some authors, arguing that the only unique features of PTSD are the presence of a severe stressor and reexperiencing of the trauma (Breslau and Davis, 1989). These authors discuss the overlap between the PTSD symptoms and other disorders such as depression anxiety, and substance abuse. For example,

Breslau and Davis (1989) argue that in depression, intrusive memories and ruminations are also common and are therefore not restricted to post-trauma responses. They conclude that trauma does not cause a specific psychiatric disorder, a view which is supported by a vast number of response patterns associated with trauma. In spite of this continuing debate, the diagnosis seems to be fairly reliable, and validated PTSD scales (e.g., the Mississippi Scale of the MMPI (Keane, Caddell and Taylor, 1988) have differentiated between PTSD and non-PTSD comparison groups among Vietnam veterans. I agree with others that the PTSD diagnosis is merely a "part of the whole" that does not incorporate all the complex psychological phenomena associated with trauma, but rather represents the most parsimonious view of post-trauma consequences that differentiates it from other disorders (e.g., Brett, 1988; Lyons et al., 1988).

Other post-trauma reactions have been noted in the literature, in additional to those described in DSM criteria. Some of these findings will be condensed in selections of literature reported in the section on the evolution of Imagery Rescripting in this chapter. Also, the psychological consequences of victimization, such as with adult survivors of incest clients will be addressed in the literature on the incest survivor syndrome (Kirschners and Rappaport, 1993).

Current Theories of Post-Traumatic Reactions

Psychoanalytic Schools of Thought, Freud's Three Theories of Trauma. Breuer and Freud, (1895/1955) described two different trauma theories in Theories of Hysteria. These theories have been described and critiqued by Krystal (1978). The first was the "unbearable affect theory," which emphasized emotions which overwhelm the psyche and result in psychological aftereffects. The second theory is described by Krystal as the "unacceptable impulse theory," which proposed that traumatic events create a conflict between the ego and some idea presented to it. Freud (1920/1955) subsequently described psychic trauma as a process by which the ego is overwhelmed by stimuli, causing a break in the stimulus barrier. Freud (1926/1959) later integrated these two theories of trauma by suggesting that anxiety acted as a signal of danger and that "automatic anxiety" happened when repression failed to protect the psyche from overwhelming affects.

Freud distinguished between two major effects of trauma by focusing on repetition compulsion. This formulation originally emerged in order to explain the traumatic dreams of World War I veterans. The first effect was described as a repetition phenomena, in which the person reexperiences the traumatic event, in order to master it. The second effect was described

as the defensive process of avoidance, denial or inhibition. These ideas later became elements of Horowitz's information processing model (1976) and have been designated as the hallmark of post-trauma reactions (DSM-III, American Psychiatric Association, 1980). More recently, Roth and Cohen (1986) described an approach-avoidance model of coping that focuses on the costs and benefits of each of these coping orientations.

Krystal's theory of catastrophic trauma. Henry Krystal (1978, 1984) has developed the most comprehensive psychoanalytic model of trauma and written extensively about the survivors of extreme catastrophes, such as in the Nazi holocaust. In this model, Krystal places a distinction between adult and childhood experiences of trauma. The crux of this distinction lies in crucial differences in emotional development, especially on how individuals tolerate strong emotions. In the early stages of development the emotions are primarily somatized, undifferentiated, and nonverbal. Therefore, when affect is intense and not modulated, the child is not able to defend against this change, resulting in a state of utter helplessness.

On the other hand with adults (Krystal, 1978), emotions become increasingly desomatized, differentiated from bodily states, and associated with language. Therefore, adults can better anticipate and defend

themselves in threatening situations of intense emotions, thus, Krystal suggests trauma is experienced differently by adults.

Lifton's Symbolization Theory of Trauma. Psychiatrist Lifton has contributed to the understanding of traumatic stress. Based on studies of survivors of Hiroshima (1968), natural disasters (1976), and the Vietnam War (1973) Lifton has developed a theory of trauma founded on the person's symbolization of their life experiences. This theory proposes that individuals develop images and symbolic forms of their life experience which contribute to a sense of continuity or discontinuity (Lifton, 1976). Lifton proposes that trauma disrupts these primary symbols.

Self Psychological Theories. Within the psychoanalytic tradition and clinical social work, a self psychology perspective of PTSD has evolved, reflecting some of Kohut's ideas (1971, 1977). Originally Kohut asserted that repeated empathic failures by self-objects (persons who are an extension of the self, such as early parental figures) are at the root of all severe psychopathology. Self-psychologists believe that a cohesive self concept comes from positive "mirroring," in which the self-object reflects back to the child a sense of self worth. As the self structure

matures, the person becomes less dependent on the self-objects to supply these basic needs.

Although Kohut, like many psychoanalytic thinkers stressed primarily, the assaults to the self that occur in childhood, some theorists in the field of traumatic stress propose that this perspective is necessary to understanding the self pathology that is sometimes associated with extreme trauma (Brende, 1983; Ulman and Brothers, 1988).

Cognitive Theories

Horowitz's Information Processing Model. Mardi Horowitz (1975, 1976, 1979), was a pioneer in the area of stress response syndromes, and has attempted to explain PTSD within a cognitive theory of information processing. The essence of this Model is on the impact of trauma on cognitive schemas, and the role of control (defenses) in regulating the processing of information. The three basic elements in Horowitz's theory are:

(1) Active memory storage has an intrinsic tendency toward repeated representation of its contents.

(2) This tendency will continue indefinitely until the storage of the particular contents in active memory is terminated, and

(3) Termination of contents in active memory occurs when cognitive processing has been completed. (Horowitz, 1975, pp 1461-1462).

Mc Cann and Pearlman (1990) explain this theory by asserting that essentially, until the traumatic event can be integrated into existing cognitive schemas, the psychological representations of the event are in the active memory, which tend to repeat the representation. Therefore, intrusive thoughts and images about the trauma are accompanied by waves of intense, uncomfortable emotions. Emotional numbing and denial frequently follow these states, as defenses against becoming emotionally overwhelmed.

The Shattering of the Assumptive world

Recently, some researchers have discussed how victimizing life events can disrupt or change a person's basic assumptions about self and the world (Epstein, 1985; Janoff-Bulman, 1985; Roth and Lebowitz, 1988; and Young, 1994).

Most recently, the parallels between theories derived from social cognition research, and object relations have been elaborated by Western (1989).

Biological and Behavioral Models

Biological Theories

As previously noted, a biological conceptualization of PTSD has a long history, dating back to Freud (1920/1953) and Kardiner and Spiegel's conceptions about war neurosis (1947).

In most recent years, Van der Kolk (1988) has advanced a biological model of trauma which hypothesizes biological changes in response to trauma.

Behavioral Theories

Behavioral theories are based both on classical conditioning theory and two-factor learning theory. Learning theory has explained the persistence of symptoms of anxiety, avoidance, and biological hyperarousal associated with PTSD. For example, according to classical conditioning theory, the experience of threat is an unconditional stimulus which evokes the unconditioned response of anxiety and fear. Previously neutral stimuli which became associated with the threat condition become conditioned stimuli and acquire the capacity to produce conditioned responses. This model assumes that the conditioned fear response is

directly linked to the particular circumstances surrounding the traumatic event, with stimulus generalization occurring over time. Consistent with learning theories, persons learn to avoid cues that evoke the conditional fear response. Gradually, the avoidant behaviors that develop in response to conditioned stimuli are negatively reinforced by a reduction in anxiety, thus making this pattern very resistant to extinction.

Recent evidence suggests that persons who avoid opportunities for extinction are likely to experience more severe long-term distress (Wirtz and Harrell, 1987). This position has been supported in the longitudinal research on long-term reactions to rape.

Overall, the behavioral and biological theories do provide a model for understanding a subset of post-trauma symptoms with the benefit of shaping specific treatment interventions targeted at reducing anxiety and avoidant patterns. This will be reviewed later in the study regarding Imagery Rescripting Therapy.

Learned Helplessness

The paradigm of learned helplessness has frequently been used as a way of conceptualizing post-trauma reactions which include depression, futility, and passivity. Walker (1977-1978) was one of the first to propose

this paradigm to explain the behavior of battered women. Seligman (1975) originally proposed that learned helplessness arises when people believe their responses will not influence the future probability of their environmental outcomes.

Summary

This brief review of various theories of post-traumatic reactions, such as psycho-analytic schools of thought; Lifton's symbolization theory of trauma, self-psychological theories; cognitive theories and the biological and behavioral models; describe the wide range of PTSD conceptualizations which have been offered to account for the complex phenomena associated with PTSD. Each approach helps explain different aspects of these reactions, with some models, such as the behavioral and biological ones, generating clearly defined treatment paradigms and others providing more general frameworks for conceptualizing the phenomena. I do not intend to critique these various theories in any depth, but to present these theories as a context for understanding the roots, the nature, and the efficacy of a new treatment - Imagery Rescripting Therapy with the victimized incest population of adult women survivors.

Overview of the Remaining Literature Review

In the past several years the Imagery Rescripting model has received more attention in the cognitive behavioral literature (Smucker and Niederee, 1995; Smucker, Dancu, Foa and Niederee, 1995; and Smucker et al, 1996) and the public lecture circuit. The discipline of social work and the field of traumatic stress have only recently begun to view this treatment model as relevant for further investigation.

Most of the remaining literature has been focused on presentation of Imagery Rescripting in the framework of abuse-related schema changes and PTSD with the female incest survivor in her environmental context.

This literature review will continue to examine the following areas:

(a) The Theoretical Framework,

(b) The Evolution of Imagery Rescripting,

(c) Imagery Rescripting Treatment and Grove's theory,

(d) Research on the Incest Survivors and their families,

(e) Therapeutic context and issues, and

(f) Methodological issues with survivors of childhood sexual abuse.

Theoretical Framework

The conceptual framework for this investigation relied on an integration of several theoretical perspectives. These theories informed both the research design and the interpretation of findings. Miles and Huberman's (1984) definition of conceptual framework is "the current version of the researcher's map of the territory being investigated" (p. 33).

In designing the research questions, six guiding theories were useful. The six theories utilized were:

(a) Information Processing Models of PTSD,

(b) Schema Theory,

(c) Memory Research,

(d) Imagery Rescripting theory,

(e) Feminist social work perspective on societal context, and

(f) Psychosocial social work perspective on societal context

Information processing models of PTSD, as explicated by Rachman (1980), Horowitz (1979, 1986), and Resick and Schnicke (1992, 1993), has informed this study by conceptualizing the recurring traumatic memories of the survivor within a PTSD framework likewise, schema theory has also guided this study by conceptualizing the recurring traumatic memories as part of the client's core schemata.

The third theory on traumatic memory, was researched by Briere, (1992), Herman, (1992), and especially Van der Kolk and Van der Hart, (1991). They emphasized that understanding the nature of traumatic memories,

how they are encoded and accessed, and how they differ from non-traumatic memories is essential to effective treatment of traumatized abuse victims, (This will be further developed in the section on the evolution of Imagery Rescripting).

The following is a brief description of the fourth theory of **Imagery Rescripting**. It is an imagery-focused treatment designed to simultaneously alleviate PTSD symptoms and change abuse-related beliefs and schemas of adult survivors of childhood sexual abuse. **The treatment intervention of Imaginal exposure** is initially used to access the traumatic memory "network" and re-experience the original trauma with its connected painful affect. **The intervention of Imaginal Rescripting** is then employed to (1) challenge and change the distressing recurring images of the PTSD response, and (2) facilitate changes in the meanings at the schema level (e.g. helping the client to change her helplessness and powerlessness schemas by replacing victimization imagery with mastery imagery). Briefly, imaginal exposure and rescripting allows the abuse-

related schemas to be addressed directly through the eyes of the traumatized **child** and then challenged, changed, and reprocessed through the eyes of the empowered **adult** using **self-nurturing imagery**.

From the feminist social work perspective, violence within intimate relationships is viewed as a pattern of behaviors and policies designed to control women and maintain male dominance. The cornerstone of feminism rests on the idea that society and its institutions, including the **family**, are patriarchal (Davis, 1995).

I affirm John Briere's (1989) view of the cultural aspects of the survivor's victimization at minimum fourfold:

(1) The devaluation and exploitation of those with lesser social power (women, children, elderly) - each of whom are targets of abuse in North America;

(2) cultural dynamics which deny or minimize the results of such victimizations;

(3) social reactions to the abuse survivor's subsequent behavior based on her "abnormality"; and

(4) socialization of the therapist so he/she, too, is prey to such aspects and then, maybe less able to optimally facilitate the survivor's process of recovery (p. 61).

The final theory in the theoretical framework is the psychosocial or "person-in-situation perspective" which permeates all social work practice. The distinctive practice model (Hollis, 1964; 1972) frequently used by social workers focuses on the study and treatment of persons in transaction with their socioeconomic-political environments.

Of the utmost importance is the context of **national health care reform** in the United States and its "Big business" demands made on employers, consumers and providers. In this very competitive environment many managed care organizations are seeking providers who treat with the briefest and most effective interventions for specific health and mental health problems. The concern for the consumer is quality health and mental health care at an affordable price.

Therefore, these theoretical approaches of information processing models, schema theory, memory research from a feminist social work perspective and psychosocial work perspective have provided a guiding framework for this investigation about Imagery Rescripting and Incest.

Summary

The research design is illustrated in the following two diagrams.

Imagery Rescripting, with its theoretical assumptions and sequence, is based on information processing models of post-traumatic stress disorder (PTSD), schema theory and traumatic memory research theory within the societal context, as viewed from a feminist social work perspective and psychosocial social work perspective. Within the healing process of the therapeutic context for the incest survivor, both the primary client and the cross-validating client progress through the phases of therapy. Also the interactional therapist structure, obtained by the application of P-technique, does inform the major treatment components of Imagery Rescripting – imaginal exposure, and imaginal rescripting using self-nurturing imagery (see Figure 1).

The next diagram illustrates the major specific interventions of Imagery Rescripting therapy, with its anticipated concurrent client change. For example, both imaginal exposure and imaginal rescripting alleviate the symptoms of PTSD and facilitate the schema change from abuse schemas to more adaptive schemas.

The self-nurturing imagery loosens and changes the abuse-related schemas to more adaptive ones and moves the client through growth in

self-calming and self-nurturance. (The abuse survivors have special difficulty comforting and calming themselves).

Imagery Rescripting therapy is the independent variable within the therapeutic context, which provides the specific treatment interventions, which in turn change the specific client problems of disturbing PTSD symptoms, abuse-related schemas (such as powerlessness) and client growth in self-calming and self-nurtuance (see Figure 2).

Based on the literature critique, some of the positive assumptions underlying Imagery Rescripting are listed below:

- empathic, therapeutic relationship
- client - centered
- abuse - focused
- activating of traumatic memory structure
- providing corrective information
- requiring daily homework
- use of Socratic questioning
- use of client self-control techniques (e.g. journalizing)
- non-directive therapist role during the rescripting process

- client education regarding (IR) treatment
- expansion of cognitive-behavioral theory
- use of repeated measures during therapy
- contract for client safety
- use of imagery
- processing client progress and treatment concerns

Likewise, based on the literature critique, the following negative assumptions underlying Imagery Rescripting are noted below:

- Often the client is retraumatized during the imagery exposure and rescripting processes.
- (IR) lacks the educational component of normalization within a victimizing culture.
- (IR) lacks refinement of differential diagnosis of client complaints with matching specific interventions (See Grove and Panzer, 1989).
- (IR) lacks comprehensiveness in its current state of development.
- (IR) operates more as an individual model, rather than a relational model (some group work within an inpatient setting has been done).

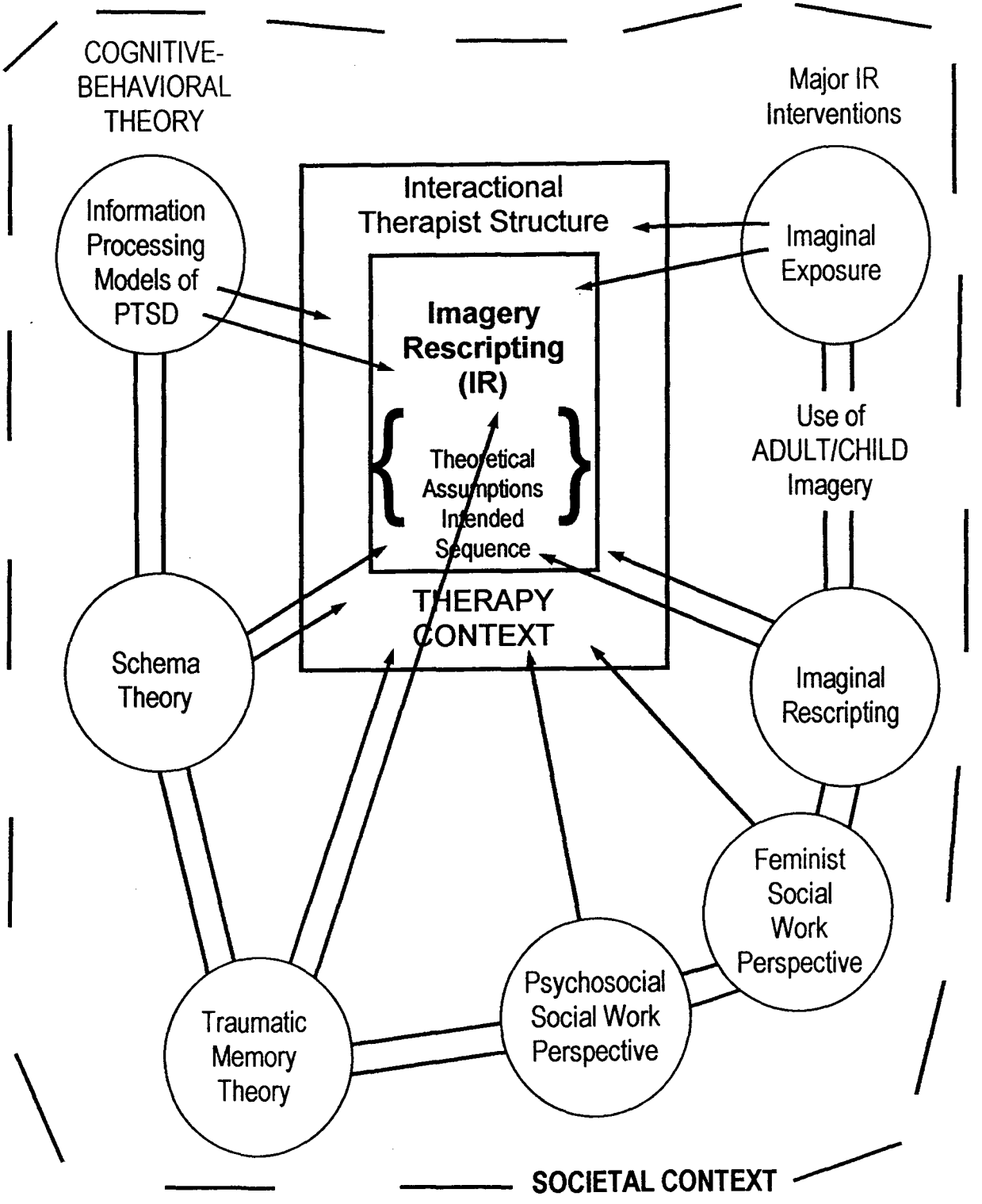

Figure 1: Theories of the Study of the Conceptual Framework

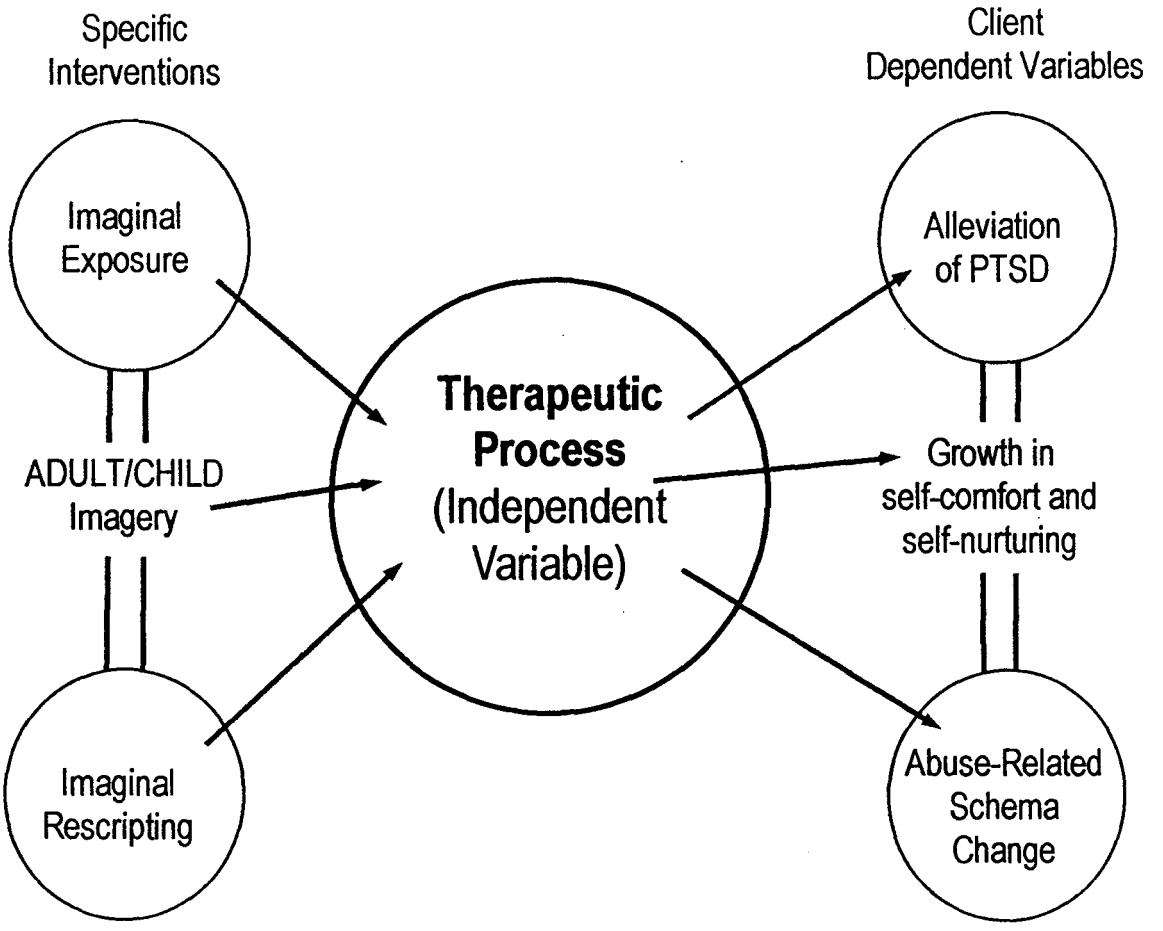

Figure 2: Variables of theConceptual Framework

The Evolution of Imagery Rescripting

Information Processing and PTSD

Numerous authors have explored what constitutes clinical effective emotional processing of trauma and the specific interventions used to accomplish this goal. Rachman (1980) stated that successful emotional processing "Can be gauged from the person's ability to talk about, see, listen to or be reminded of the emotional events without experiencing distress or disruptions" (pp. 51-52). Horowitz (1979, 1986) emphasized the role of unassimilated material, whereas Mc Cann, Pearlman, Sakheim and Abrahamson, (1988), and Resick and Schnicke (1992, 1993) stressed the importance of both assimilation and accommodation in the processing of trauma. As Resick and Schnicke (1993) emphasized, either process may result when persons are exposed to schema-discrepant information. With assimilation, the information itself may be changed in order to fit within preexisting schemas. For example, in cases of incest, a negative degree of assimilation could be this, "Daddy wouldn't do anything bad, so maybe it wasn't really bad after all." However, when accommodation happens, the schema itself is changed to take in the new discrepant information. For

example, trauma may disrupt a child's perception of self-efficacy and result into a schema of powerlessness.

Concerning the structure and change of traumatic memories, Lang (1977; 1979) developed a theory of emotional processing in which he conceived that the fear-inducing memories are encoded in a neural network of stimulus and response data and the subjective **meaning** of the traumatic stimuli and responses. Lang believed that vivid response imagery and affective involvement are crucial if the fear network is to be accessed during therapy and processed in a healthy adaptive way.

Foa and Kozak (1986) have extended Lang's theory, putting more emphasis on the cognitive meaning of the trauma. They defined emotional processing as "the modification of memory structures that underlie emotions" and noted that two conditions for successful emotional processing and fear reduction are:

(1) Activation of the fear memory, and

(2) incorporation of new information which is incompatible with the existing traumatic elements of the fear structure. They suggested that prolonged exposure, which confronts the fear stimuli directly through imaginal flooding, achieves the activating

of the fear memory and provides for corrective information to be integrated.

Even though the prolonged exposure treatment has demonstrated positive outcomes with adult rape victims (Rothbaum and Foa, 1992), it does not provide corrective information regarding maladaptive beliefs (Resick and Schnicke, 1993). So, Foa and Kozak's (1986) definition of meaning may need to be extended to the meanings experienced by incest victims with PTSD. The latter population's schema-based posttrauma responses (e.g. feelings of powerlessness and helplessness, mistrust, self-hatred, abandonment and unlovability) frequently accompany intrusive phenomena.

Some authors have stressed that abuse-related cognitions are significant elements of posttrauma symptoms and need to be a major focus of treatment with the population. In her publications on the "shattering of assumptions," Janoff-Bulman (1985, 1989) asserted that trauma shatters the victim's most basic assumptions (i.e., schemas) about the benevolence and meaningfulness of the world, self-worth, and personal invulnerability. Finally, Mc Cann and Pearlman (1990) proposed that disruptions in schemas are frequently pathological in areas of trust, safety, power, esteem, independence, intimacy and frame of reference.

A Schema-Focused Information Processing Model

Both Smucker and Niederee (1995) and I propose Imagery Rescripting to be an expanded information processing model in which the recurring flashbacks and memories of abuse survivors are conceptualized both within a PTSD framework and as part of the client's core schemata. Our definition of meaning exceeds Foa and Kozak's (1986) emotional processing model to include abuse-related schemas, such as abandonment and mistrust. Change of such beliefs then, does become a crucial component of therapy. Thus, the client is helped to construct new ways of thinking about herself and the meaning of the trauma using Imagery Rescripting - a schema-focused information processing treatment model.

Traumatic Memories

Many authors (Briere, 1992; Herman, 1992; Van der Kolk and Van der Hart, 1991) have stressed that understanding the essence of traumatic memories, how they are encoded and accessed, and how they differ from non-traumatic memories is necessary for effective treatment of traumatized abuse victims.

Van der Kolk and Van der Hart's research (1989, 1991) has discovered that, in contrast to narrative memories, **traumatic memories**:

(1) Lack verbal narrative and context,

(2) are state dependent,

(3) are encoded in the form of vivid images and sensations which cannot be accessed by words alone,

(4) are difficult to assimilate and integrate because they are "stored" differently and are frequently dissociated from conscious awareness and voluntary control, and

(5) frequently remain in their original form and are not changed over time.

The age of the victim at the time of the abuse is another factor which influences how abuse memories are encoded (Staton, 1990). Bruner (1973) observed that a child's earliest memories are encoded in the sensorimotor system. Between the ages of two and seven, visual representation becomes dominant, while verbal representation develops gradually and may not be integrated with the kinesthetic and visual manner of representation until adolescence.

Use of Imagery in Therapy

These qualities of trauma and memory do have implications for treating incest survivors. Since childhood abuse memories are encoded primarily in images, then using imagery to change their meanings would seem advantageous. In fact, some cognitive-oriented therapists have advocated the use of imagery (Anderson, 1980; Beck et al, 1985; and Edwards, 1990) as the major therapeutic agent in work with trauma victims, whose affective disturbances are embedded in traumatic imagery. Staton (1990) stated that in the absence of corrective imagery, abuse imagery, may remain no matter how much "talk" occurs. Smucker and colleagues (1995, 1996) have elaborated further on the change of traumatic imagery in order to restructure the abuse and its meaning within a therapeutic context.

Therefore, it would appear that based on the cognitive and information processing literature, therapy with this population is enhanced when:

(1) imagery is actively used during memory recall, reprocessing, and restructuring; and

(2) the level of affective state during imaginal exposure is similar to what was experienced earlier at the time of the trauma.

Summary

The presence of both PTSD symptoms and abuse-related schemas in incest survivors indicate the need for a therapy which simultaneously treats the intrusive PTSD symptoms and the underlying abuse-related beliefs and schemas as such, Imagery Rescripting was developed as an expanded information-processing schema-focused model that conceptualizes the continuing traumatic memories of the survivor both within a post-traumatic stress framework and as part of the individual's core schemata. Imagery Rescripting's major components are **imaginal exposure**, **imaginal rescripting**, and **self-nurturing imagery** and is designed to go beyond extinction models, to change recurring abuse images, facilitate more adaptive schemas, and enhance one's capacity for self-nurturance -- all of which are thought to be essential ingredients for "effective emotional processing" to occur. The primary goals of Imagery Rescripting therapy are:

(1) to decrease physiological arousal;

(2) to eliminate intrusive PTSD symptoms (e.g. nightmares and recurring flashbacks);

(3) to replace victimization imagery with mastery imagery

(4) to change abuse-related cognitions concerning self and others; and

(5) to develop enhanced ability to self-soothe and self-nurture

(See Figure 5 for a diagram of effective emotional processing of traumatic incest).

Imagery Rescripting Treatment

The conceptual seeds of Imagery Rescripting (an outgrowth of Beck's Cognitive Therapy Model) were planted within Mervin Smucker, Ph.D., when he began a post-doctoral fellowship with Dr. Aaron Beck at the Center for Cognitive Therapy at the University of Pennsylvania.

In 1989, Psychologist Dr. Smucker accepted a joint appointment at the Medical College of Wisconsin and Milwaukee Psychiatric Hospital of Milwaukee, Wisconsin. There he specializes in treating an inpatient PTSD population and an outpatient population at the Center For Cognitive Therapy. Teaching, therapy, research, and writing are part of Dr. Smucker's work, especially regarding his Imagery Rescripting Model.

The standard treatment program of Imagery Rescripting does consist of ten sessions and two follow-up sessions, ranging in length from 90 minutes to two hours each and is further described in Smucker and

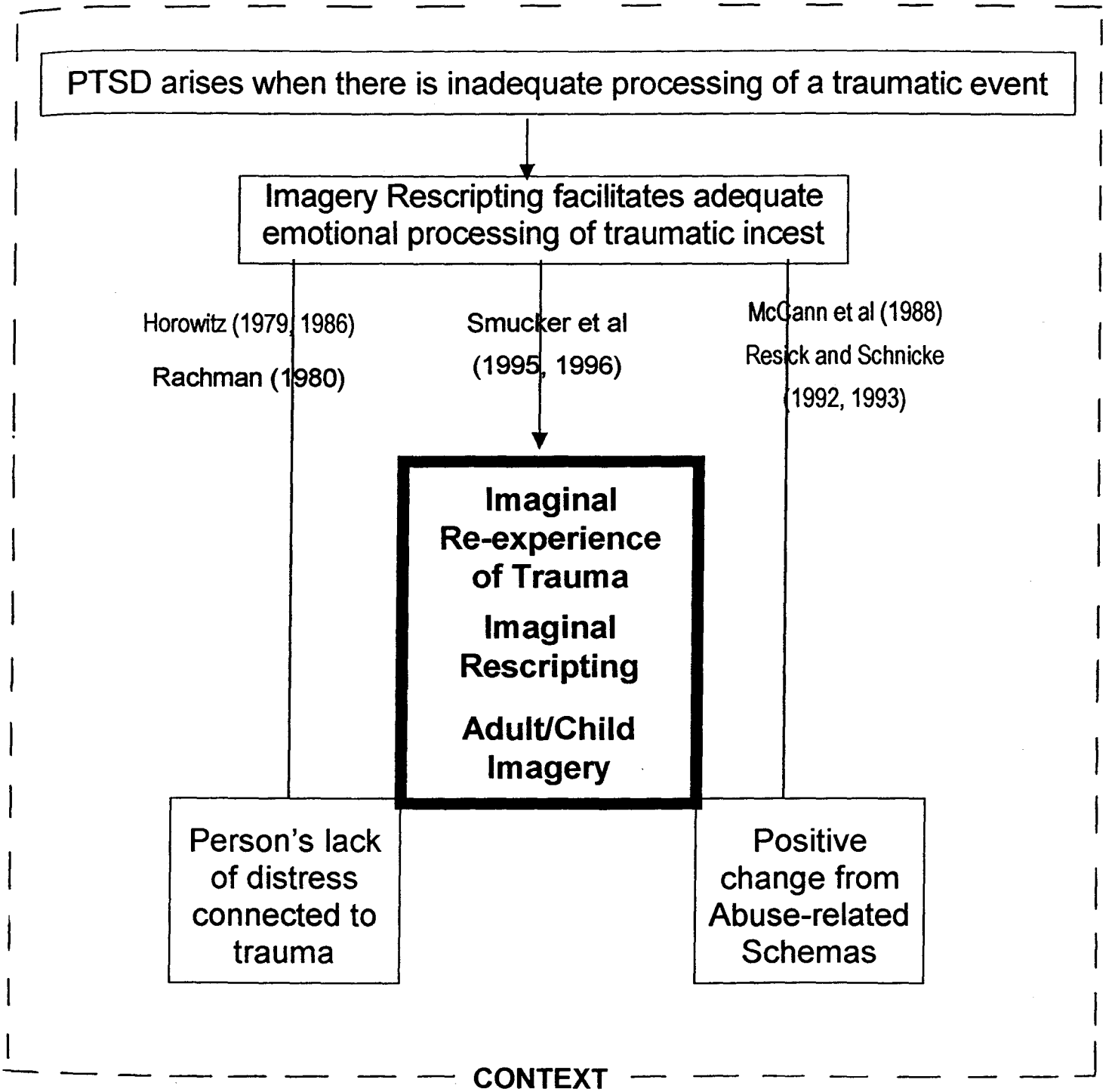

Figure 3: Theoretical Assumptions of Imagery Rescripting With Traumatic Incest

colleagues' treatment manual of Imagery Rescripting for adult survivors of childhood sexual abuse (1996).

Clinical Outcome Pilot Study

The findings of the unpublished pilot study reported at a Behavior Therapy Convention, (November, 1993) were favorable to Imagery Rescripting. Briefly, the study consisted of 12 subjects (six subjects in each treatment group), all of whom met DSM-IIIR's criteria for PTSD at pre-treatment. Subjects were randomly assigned to either Imagery Rescripting or the Prolonged Exposure/ Stress Inoculation (PE/SIT) group. Both treatment groups consisted of nine sessions each, (at that time). At the end of treatment, all subjects in both groups exhibited a significant reduction in PTSD-related symptoms and actually no subject in either group met criteria for PTSD, results which were maintained at three months and six months follow-up.

As indicated in Chapter 1, one of the limitations for this researcher was the lack of available data from this unpublished clinical outcome pilot study of 1993.

Dr. Edna Foa, an expert in exposure-based interventions (mainly with rape-related PTSD survivors) was a major investigator and participant

in the clinical outcome study (1993). In her previous experimental outcome study (1991), she used two types of cognitive-behavioral procedures developed for the treatment of other anxiety disorders which have been applied to PTSD sufferers: **Exposure treatment**, in which clients are confronted with the feared memory or situation, and **anxiety management training**, in which clients are taught a variety of skills to manage anxiety in daily life. It is my conjecture that Prolonged Exposure/Stress Inoculation Treatment (PE/SIT) in the Imagery Rescripting clinical outcome study (1993) was likely a combination of exposure treatments and anxiety management training previously mentioned. (For further research details, see Foa et al, 1991).

Meichenbaum (1994), national expert on PTSD, gave some general evaluative comments on exposure-based interventions in treating adults with PTSD. He concluded that exposure-based interventions have demonstrated reductions in PTSD clients' levels of distress, intrusive memories, and physiological arousal. Meichenbaum stated that the effectiveness of exposure therapies have been primarily with combat veterans, rape victims and children living in a war zone, while their effectiveness with other populations such as adult survivors of child abuse have <u>not</u> yet been demonstrated. He continued by specifiying that these

interventions have been primarily effective in reducing so-called "positive" symptoms of PTSD (namely, psychophysiological arousal and startle response, intrusive thoughts, nightmares and anger). However, changes in "negative" symptoms of PTSD are less evident (namely, psychic numbing, alienation, and restricted affect). Green et al (1980) have observed that "positive" and "negative" symptoms of PTSD may have different determinants and different courses and this may contribute to their differential response to treatment.

Solomon et al (1992) noted that direct therapy exposure may be contraindicated for clients who have a history of psychiatric disorders.

Allen and Bloom (1994) indicated that exposure techniqes are contraindicated by "marked" psychological dysfunctions, personality disorder, impulsiveness, suicidality, substance abuse, or treatment resistance (p. 428).

Pitman et al (1991) raised similar concerns who reported that 6 of 20 combat-related PTSD patients treated with flooding experienced serious complications including **retraumatization, increased anxiety and panic symptoms, alcohol abuse, and obsessional thinking**. Therefore, much care is required in selecting candidates for direct therapeutic exposure.

See Kilpatrick and Best (1984) for cautionary suggestions on treating sexual abuse victims with exposure-based interventions.

When considering exposure-based interventions (or for that matter any interventions) there is the need to insure that the **client is a collaborator** throughout treatment (with the clients being "informed" and "in charge" throughout therapy) Meichenbaum (1994) concluded his evaluative comments by asserting that at this point, we do not know how best to combine exposure-based interventions with other forms of treatment.

According to Dr. Smucker, one of the research investigators of the clinical outcome study (1993) and originator of Imagery Rescripting, these findings were especially favorable for Imagery Rescripting given that

(1) four of the six subjects in the Imagery Rescripting group were treated by four different therapists who were part of Dr. Foa's clinical research group at the Medical College of Pennsylvania, each of whom had received only 2-3 hours of formal training in Imagery Rescripting;

(2) all of the subjects in the PE/SIT treatment group were treated by Dr. Foa's therapists who were very well trained in PE/SIT and had extensive clinical experience with PE/SIT; and

(3) detailed analyses of several session transcripts such as in this study, demonstrated significant change of abuse-related schemas.

Dr. Smucker asserted that although the positive outcome study was not definitive, and further outcome research is needed to test these results (Smucker et al, 1996). Currently, this is the only outcome study of any kind which has been done which assesses the efficacy of treatment with adult survivors of incest-related PTSD.

Recommended Inclusion Criteria

Currently the recommended criteria for types of clients eligible for this treatment are two:

(1) A minimum of one incident of childhood sexual abuse by a family member or significant other (e.g. caretaker, grandparent, parent's lover, friend of family or by person(s) in a power position (including teacher, clergy, and neighbor) or by a stranger; and

(2) The person recalls most or all of a traumatic abuse event in the form of intrusive memories, recurring flashbacks or continued nightmares.

Recommended Exclusion Criteria

The following recommendations are considered to be exclusionary of Imagery Rescripting treatment:

(1) Living in a highly abusive situation. (Actually, therapy should first concentrate on helping clients regarding the abusive situation);

(2) Clients who are diagnosed with current substance or alcohol abuse, severe dissociative identity disorder, and schizophrenia;

(3) Outpatient clients with severe depression and high suicidality;

(4) The presence of vague or incomplete abuse memories (In these cases, Imaginal exposure alone may be an initial intervention, provided the therapist is non-suggestive and the client's overall stability is considered);

(5) Inability to visually focus on a specific abuse memory because of dissociating during imagery, or being flooded with intrusive imagery which prevents the implementation of either the exposure or rescripting element of treatment, (Only in severe cases is this likely to be a problem);

(6) The pervading presence of emotional numbing during exposure and/or rescripting, which keeps the client from re-experiencing and "working through" the pain associated with the abuse.

Grove's Theory of Resolving Traumatic Memories

Therapist David Grove (Grove and Panzer, 1991) has worked for a disciplined use of language which allows the information born of traumatic experience to be resolved and transformed. His approach values the infrastructure of language as the primary source which both defines the pathology and contains the seeds of healing. Freeing the client's experience from the secondary processing language of words into the primary processing language **of metaphor, symbol,** and **imagery** often brings the experience to life without retraumatizing the client. The procedure makes the experience malleable and amenable to change.

New discoveries relating to the four different ways that clients formulate their complaints are reported. On the basis of these discoveries, a new therapeutic language - "clean language" - is formulated for the therapist's clinical use. "Clean language" brings trance without induction and helps the clients discover the infra-structure of their complaints, while allowing the therapist to communicate with nonconscious functions. In utilizing clean language, resistance is not evoked, and a healing evolution of the memories, metaphors, symbols, and semantic constructs underlying the client's disturbance is facilitated. Breakthrough sessions are frequently

obtained. In many instances, clients provide all the ingredients, knowledge, and energy for their own healing.

Comparison With Imagery Rescripting

Theoretically both models of Grove and Smucker are client-centered, and use a disciplined language (Smucker - Socratic questioning and Grove "clean language" - language which insures that the client meaning and resonance remain wholly intact).

Both work with the information processing of trauma. Both employ primary process, such as in imagery, but Grove's research uses more differential diagnosis of the client's trauma from the client's unique expression of her complaint in her own words, thereby locating the exact moment of the greatest density of the pathology in a particular individual. Grove's model is the ultimate in non-directive therapy, whereas Smucker's direction is couched in non-directive ways.

Grove uses "memories as intervention" in a way which is not retraumatizing to the client, whereas Smucker's therapy still retraumatizes the clients, especially during the exposure stage and rescripting stage. (See Grove and Panzer for further theory, 1991).

The Incest Survivor Syndrome

While the specific relationship between early traumas and the later development of effects in survivors is still being studied (Reicker and Carmen, 1986), it has become clearer that a host of symptoms are generally related to the experiences surrounding the incest. We need, to understand better the special needs of this population. Specifically, clinicians require a more comprehensive picture of the client symptoms brought to therapy and how these presenting problems are related to the incest. Only then can we formulate more successful treatment plans. The symptoms include anxiety disorders and chronic depression, low-self-esteem, eating disorders, drug and alcohol abuse, sexual dysfunction, and abusive marital or incestuous family relations. The Kirschners and Rappaport (1993) have classified the most common problems presented by survivors into the following four areas: **cognitive, emotional, physical/somatic**, and **interpersonal**. While other classifications are possible, they simplified the task by presenting those issues which most often motivate incest victims to seek psychotherapy. Since most survivors do not describe childhood incest as their reason for coming to therapy, clinicians must be aware of the possibility of incest if their clients present with problems in several of these categories. But while survivors do not

have to present with serious psychopathology in all four areas, they frequently fall on a continuum of moderate to high dysfunction in all categories. This core of problems form the four areas and their interaction effects of the **incest survivor syndrome** according to Kirchner et al. (1993).

Cognitive Problems

> **"I'm dirty . . . bad . . . damaged."**
> **"I'm useless . . . good for nothing."**
>
> – *Incest Survivors*

The most pervasive difficulties with which survivors struggle are issues in self-concept and self-esteem. Herman (1981) and Lundberg - Love (1990) reported that nearly 100% of their female survivors felt damaged, stigmatized, or irreparably marked.

Some studies have documented the clinical observation that most survivors suffer from some degree of dissociative disorder. Browne and Finkelhor's (1986) excellent meta-analysis concluded that dissociation is a long-term consequence of incest.

Emotional Problem

"I'm terrified of the dark."
"I want to die. Nothing has any meaning for me."

– *Incest Survivors*

Survivors often approach therapy because of symptoms of **anxiety** and **depression**. In Kirschner et al (1993) the authors view anxiety and depression as long-term post-traumatic reactions to incest.

According to the study of Briere and Runtz (1986), survivors are much more prone than controls to consider or attempt suicide. They are also more prone to self-mutilating behaviors using cigarettes or razor blades.

Some clients present with deadened affect and a quality of numbness.

Still another category of emotional problems of incest is a persistent feeling of **shame**. They will often report feelings of wanting to hide from the world or that they do not deserve to live. Other survivors suffer from **chronic guilt**, over almost anything.

Survivors often exhibit what Seligman (1975) has called "learned helplessness." The **seeming passivity** and **apathy** displayed by the clients

are similar to the passivity and apathy witnessed in the concentration camp survivors.

Physical/Somatic Problems

> **"I have colitis."**
> **"It's these terrible headaches that drive me crazy."**
> **"I binge eat."**
> **"I abuse drugs."**
>
> – *Incest Survivors*

Lundberg - Love, et al in their 1987 study of female survivors discovered a high incidence of somatic complaints. About 50% reported gastro-intestinal problems, pains, and headaches, while 53% were found to have eating disorders.

Interpersonal Problems

> **"I've never had a lasting relationship."**
> **"I have no desire for sex."**
>
> – *Incest Survivors*

Survivors frequently come to therapy with interpersonal issues as their primary concern. The most pervasive problems faced by survivors in relationship are around **intimacy issues**.

Some survivors present with children who have been either physically or sexually abused.

Another serious consequence of incest is sexual revictimization, such as rape.

Kirschners' and Rappaport's Research on the Family Context of the Survivor

One of the most unifying social work concepts in the diverse field (Turner, 1995), is the **person-in-situation** or environmental context of the incest survivor in this particular study. This section will explore the survivor's family of origin, the immediate context of her abuse and the foundational base of all her relationships and will apply this to the two participants in the study.

Family therapists first began to treat incestuous families in the late 1960s and to observe their **interactional styles** and their **structures**. Each type of incest occurs under somewhat unique circumstances, therefore, there are similarities and differences among the cases. Understanding key systemic and individual dynamics, can be extremely helpful to the social work practitioner. Developing hypotheses, comprehending the survivors' marital and parenting issues, making treatment plans, shaping

interpretations and interventions will be done more effectively when the social worker has a deeper appreciation of the survivor's family of origin and the type of incest she has suffered. It is in the context of these family and individual dynamics that the personalities of survivors are formed.

This section will include the types of incest and families of the two subjects as gleaned from the transcripts' analysis and the research done by the Kirschners (1993).

Father-Daughter Incest

One of the most common types of incest, and indeed, the most studied, is that between fathers and daughters. In describing this type of incest, the family pioneers (e.g., Machota, Pittman, and Flomenhaft, 1967) pointed out that incest is "a family affair" - thereby, spreading the responsibility for it among the other family members.

A sketch of the incest family includes absent mothers (physically or psychologically) in which men turned to their daughters for comfort, and even sex. The girls were estranged from their mothers and so did not report these events to them.

The distant-mother hypothesis led to other corollaries. One of the most important assumptions of therapists was that the mothers really knew

what was happening. Some Clinicians believed that even when mothers denied having knowledge about the incest, at some preconscious or unconscious level of awareness, they really "did know." Some of the mothers themselves had been victimized as children and had repressed the trauma. Their denial then, represented not only the family's suppression of truth, but also their own.

An unfortunate consequence of this perspective was that some blamed women for their husband's, brother's or son's behavior. As Leupnitz (1988) has pointed out, a subtle misogyny is built into any theoretical model that holds the woman responsible for the man's abusive behavior even when it is couched in neutral language, such as "distant." Actually, the mother-blaming interventions only compounded the problems of the victims by further disempowering and devaluing women in families.

Partially as a reaction to this viewpoint, and partially as an outgrowth of the women's movement, some social workers began to focus more on the victim or the perpetrator. Individual therapy for each of them became a standard prescription. In this model, women were the victims of male perpetrators and of a male-dominated culture and, therefore, could not be held responsible.

Our view (Kirschners', Rappaport's, and mine) recognizes the strengths of each position and seeks to avoid their limitations. Father-daughter incest is a family affair because it affects all family members and happens because there have been breakdowns in the structure of the process of "normal" family life. But there are also significant individual dynamics in these systems. Only by examining both the family and the individual issues, system, and psyche can we develop a comprehensive model for understanding and treating survivors. some of the key elements of families with father-daughter incest are, distance in the marriage, poor communication skills in the marriage, destructive triangulation of children, and the divided parental team with children inappropriately cast as parental figures.

The Father-Dominant Family

The father-dominant family is the family that has received the most study. The husbands tend to be more authoritarian and dominate the family's decision making. These authoritarian perpetrators are those who have traditionally been perceived as more emotionally disturbed than most clients, or simply as "evil." Yet to date, no research study has ever found

that abusive fathers are more disturbed than other outpatient men (Meiselman, 1978).

The psychopathology of these men, however, may appear in two areas: **Alcoholism** and **sexual dysfunction**. There is much research that demonstrates about 50% of all incest fathers can be considered alcoholics (Virkkunen, 1974; Meiselman, 1978). In these alcoholic families, the women are codependent and enable the perpetrator through their silence, fear, and distance. In the male-dominant family, the women are more distant from their spouses primarily because they are devalued in the relationship.

While the Kirschners et al (1993) in their clinical experience, have found that where father-daughter incest occurs, there is almost always marital sexual dysfunction (also see Waterman, 1986), the specific sexual problems vary from family to family. Some of their cases have no sexual activity between spouses.

Another sexual problem observed in the male-dominant families is **sex addiction**. These men have frequent sex with their wives, have sex with their daughters, and even have extra-marital affairs. Many of these sex addicts were sexually abused as children. Carnes (1992) has found 81% of his male sex addicts were sexually abused as children. Of these, 33% had

been abused by their fathers or mothers. The pattern of incest leading to sex addiction and to further incest only recently was identified and requires further study.

In sum, the male-dominant pattern historically described as the prototypical incestuous family, does exist, but only as one type of incest system. In these groups, daughters may act as their fathers' caretakers and/or as substitutes for the mothers. Physical abuse of spouses frequently is present, especially when the male is alcoholic. The couple's sexual life is dysfunctional, but differs from marriage to marriage.

Stepfather-Daughter Incest

The dynamics which occur in step-families have some similarities and some differences from the incest which occurs in intact families. The similarities are a distant and dysfunctional marital relationship; poor communication throughout the family system; and the triangulation of the daughter into inappropriate role functions.

There are several major differences between incest families and incest stepfamilies. Again, it has been the Kirschners et al's experience that incest happens infrequently in stepfamilies in which the mother is the custodial parent and also the dominant parent. The majority of stepfamily

incest cases are of authoritarian or dominant fathers in which the custodial parent, the mother, is devalued.

In these families, the mothers usually have been economically disadvantaged after their divorces, and they also lack interpersonal support. The children usually have little contact with their biological fathers and are emotionally starved. Into this family enters the rescuer, who appears to do this, but frequently, he is a predator looking for a vulnerable woman with vulnerable children. In the Kirschners' and Rappaport's experience, some stepfathers actually marry into certain families so that they have access to the female children.

Sibling Incest

Sexual play between siblings is the only type of familial sex that has been acknowledged as a more normal part of a child's psychosexual development. This attitude of normality, especially toward siblings who are close in age, has tended to minimize both the reporting of these experiences and the establishment of some reasonable rate of prevalence in society.

Russell (1986) found that 72% of the women who were sexually involved with their brothers reported being upset by their experiences.

Russell also contended that, researchers and clinicians should not minimize the impact of sibling incest, especially when it involves an older brother and younger sister.

The Kirschners' et al's experiences parallel those of Russell. They observed that two types of sibling incest inevitably leave the survivor with traumatic effects - older brother-younger sister incest and older brother-younger brother incest. In both kinds, the perpetrator's age and relative power over the victim and certain family dynamics tend to play significant roles in the trauma of the molestation.

Courtois (1988) identified three types of older brother - young sister incest:

(1) when the adolescent male experiments sexually with his sister;

(2) when an immature or socially inept brother uses his sister sexually because he is afraid of females outside the home, and

(3) when the brother is violent and rapes his sister.

In sum, the incestuous families discussed were mainly male-dominant ones which showed poor boundaries between the subsystems, the lack of marital and parental cohesion, and the expectation that the victim will function as a parental child or parental caretaker. Many of the

spouses seem to suffer from alcoholism, sex addiction, or sexual dysfunction. Some families, especially single-parent and stepfamilies, seem especially vulnerable to incest.

Application to Client 1, Dolly

Based on the analysis of therapeutic interactive dialogue of selected sections from beginning, middle and ending therapy, this section will apply some of the relational research done by Kirschner et al (1993).

Dolly was a product of the most common type of incest, that of **Father-Daughter Incest**. In fact, she was the middle girl of five girls all whom her father sexually abused, and courageously Dolly was the only female adult dealing with the incest in several types of psychotherapy. It seems from the text, that Dolly had both, a physically and psychologically absent mother and father who was intoxicated often. This family situation was definitely a "family affair" kept highly secretive. Dolly's father appeared to be the dominant, authoritarian father controlling the family lifestyle.

Whether Dolly's father is an alcoholic or whether he and his wife had marital sexual dysfunction is not known. Also, whether Dolly's father has a sex addiction is not substantiated. He does seem to be a child molester

who sexually abused, not only his five girls, but also at least one, of Dolly's children.

Application to Client 2, Kathy

Again, based on the text analysis as described earlier, Kathy was a product of **Stepfather-Daughter Incest**. The details of Kathy's particular stepfamily situation are unknown, since she is more reticent in volunteering information in the therapy session regarding her family of origin and new family configuration. Kathy mainly shares information concerning her current created family with her husband of several years.

Kathy speaks rarely about her mother in the therapeutic dialogue and never talks about her biological father.

Kathy also experienced **sibling Incest** with her three brothers. Even though the research cited indicates that sexual play between siblings is the only type of familial sex that has been acknowledged as a more normal part of a child's psychosexual development (Kirschners et al, p.68), they observed that two types of sibling incest leave the survivor with traumatic effects - older-brother or younger-sister incest. Kathy experienced sibling incest with three older brothers, in which the perpetrators' age and relative power over Kathy and very likely certain family dynamics played significant

roles in the trauma of the molestation. No other family-of-origin facts were shared by Kathy in the therapeutic dialogue.

Briere's View of Therapeutic Context and Issues in Abuse-focused Treatment

Briere (1989) believes that even more important than knowledge of abuse effects and treatment techniques is the therapist's general orientation toward working with sexual victimization. Briere proposes that survivor-oriented therapy specifically focuses on the **original abuse context** as one of the key issues in treatment, relating this early trauma to later and current experiences and behavior.

Similar to other therapies, this philosophy of abuse-focused treatment stresses **a growth model**, rather than a medical model. The survivor is not viewed as inherently "sick." but, instead, as someone who has appropriately accommodated to a toxic environment. These accommodations were "healthy" at the time of the abuse, and therefore, the client's current predicament is one of updating her survival behaviors and perceptions rather than being cured of an illness. Unfortunately, the abuse environment may have been so chronic and/or violent, that new, seemingly

contradictory, learning is often quite difficult. Often the updating of survivor behaviors is a long-term journey, both in and out of therapy. One is never "cured" of an abuse history; one can only integrate those experiences and live more fully in the present. In reality, abuse-centered therapy is less interested in client weaknesses and more focused on **client strengths**.

Transference and Countertransference

Undoubtedly, as important as are the specific abuse-focused treatment interventions, even more crucial is the quality of the therapeutic relationship per se. As with other types of relationships, both therapist and client are vulnerable to biases in perception and expectation as they move to define and understand each other. Abuse-specific treatment may be especially difficult in this regard, because it directly accesses childhood trauma and so increases the possibility that current interpersonal behaviors will be affected by historical events.

When the distortions in perception and expectation occur in the client, we refer to **therapeutic transference**, whereas, similar effects on the clinician are frequently described as **countertransference**.

Most typically, the transference process involves alterations in how an authority or a significant person is viewed based on the survivor's experience with her abuser. Psychotherapy, almost by definition, involves client interactions with a powerful, psychologically significant person in an intimate context. And probably the two most difficult client responses to deal with are rage and sexualization.

As stated in a paper by Waldinger (1987) on "Intensive Psychodynamic Therapy with Borderline :Patients" (The reader may wish to substitute the words "survivor of severe abuse" for "borderline").

> The therapist must withstand the patient's verbal assaults without retaliating or withdrawing, so the patient's hostility . . . . is understood as part of a pattern of relating to important others (p. 268).

There are two major sources of negative therapist **countertransference** to abuse-focused psychotherapy: the therapist's own childhood experience of abuse or neglect, and issues related to therapist gender.

Dissociation

Dissociation was defined in Chapter 1 as cognitive separation of an individual from her environment at times of stress (Briere, 1989).

The therapeutic context, paradoxically from the survivor's perspective, has several commonalties with her abuse experience and her therapy experience. Both involve a form of intimate relationship with an authority figure who is likely to be male. Both experiences can be emotionally painful. Both experiences demand vulnerability.

The client may **dissociate** during therapy, as she did to survive her abuse and has tended to carry the mechanism into her current life, which usually detracts from mature development and full living.

The negative impact on therapy for the client could be missing relevant material; avoiding emotional tasks; and lessening the therapeutic relationship.

Client-Gender Issues

Although sexual abuse impacts both women and men in many of the same ways (e.g., flashbacks and depression) the survivor's gender frequently affects how such abuse-related trauma will be expressed and acted upon. This is due partially as a result of social training to behave in sex-role "appropriate" ways (Helmreich, 1978). For example, the sexes are socialized differently with regard to sexuality and aggression, responses to victimization, and expressions of emotional pain. These variations impact

how the survivor copes with the effects of abuse and how he/she will respond to therapy.

Regarding sexuality and aggression, our society has tended to socialize men to be sexually aggressive and women to be nurturant, passive, and easily victimized.

Concerning their reaction to abuse-related emotional trauma, most males grow up in our society learning to suppress verbal expressions of pain or discomfort, which may delay or keep them from therapy. Females, on the other hand, are more likely to communicate their feelings to others. This expressiveness can have an "upside" that of benefiting from catharsis and emotional insight during therapy. The "downside" is that such women are likely to look "worse" than equivalently injured males and may be in fact, labeled as "overly dramatic."

Finally, the sex-role-related concerns which involve the actual process of therapy, relate to differences in male versus female awareness and expression of emotions. The male survivor's tendency is to deny, suppress, and/or intellectualize his abuse history, which reduces the amount of catharsis and emotional insight he is able to accomplish during treatment. Additionally, the male survivor's frequent choice of action over affect may result in higher levels of treatment-related acting out, rather than

dealing with affect. Interestingly, because males in our society are less likely to be punished for anger or expressions of hostility, this is one emotion that the therapist typically does not have as much trouble "freeing up."

In contrast to the male experience, female abuse survivors have been trained to avoid anger and express only the less threatening emotions, such as sadness and fear (Agosta and Loring, 1988).

Besides emotional expression, male and female survivors often differ in their response to power or control issues during therapy and how these issues are manifest, in turn, depends to some extent on the sex of the therapist. For example, power dynamics are perhaps most obvious when the therapist is male, partially because he is likely the same gender as the client's perpetrator. However, male survivors frequently attempt to go "one up" or "one down" with male therapists, according to their assessment of their own vulnerability and that of the clinician.

Methodological Research Issues with Survivors of Childhood Sexual Abuse

Respected researchers Beutler and Hill (1992) describe areas within process and outcome research that would be applicable to studying adult

survivors of sexual abuse, and identifying methodological issues in these research areas.

They assume that treatment processes and outcomes are to be influenced by both **input variables** and **extra therapy events**.

Input variables are those characteristics of therapists and clients which exist before therapy. The most commonly studied of these variables include client and therapist demographic characteristics (age, gender, ethnic background), are relatively stable over time and not subject to direct influence by therapy. Others, like coping styles and personality, although stable, are likely to be influenced by therapeutic efforts and can be changed during treatment. Other qualities are not so stable and are specifically related to issues addressed in therapy. In studies of adult survivors of sexual abuse, examples of these latter input variables may include therapist experience treating sexually abused clients, therapist attitudes toward sexual abuse, client distress levels, client and therapist expectations for treatment, and previous client sexual experience.

Client Variables

Regarding clients, some important states and traits may be client attitudes toward the abuse or the abuser, client motivation for treatment

and readiness for change, whereas those characteristics which cannot be changed are (e.g., demographic characteristics, age of onset of the abuse, personality variables, family history, diagnosis) have importance to the degree they indicate some specific need within the treatment program.

Therapist Verbal Response Modes

In examining process research, most research on therapist variables has analyzed therapist response modes defined as the grammatical structure of the therapist's discourse, including such categories as **confrontation**, **interpretation**, and **question** (Hill, 1986). Findings demonstrate that therapists from different orientations use response modes that fit their theoretical views (Elliot et al, 1987; Hill, Thames, and Rardin, 1979; Stiles, 1979; Strupp, 1957). However, the strongest evidence regarding specific response modes indicates that therapist interpretations are helpful (Barkham and Shapiro, 1986; Elliott, 1985; Hill, Helms, Tichenor, 1988). Generally, however, according to Beutler and Hill (1992), response modes do account for only a small proportion of the variance in immediate outcome, suggesting that the effectiveness of techniques may be influenced by other factors such as **therapist** and **client variables**, **stage of treatment**, **timing**, and **quality of intervention**.

In the specific area of the treatment of sexual abuse survivors, an important and yet unanswered question is whether therapist response modes are differentially helpful with different types of adult survivors (e.g., early and late presenters; Sgroi and Bunke, 1989), at various phases of treatment. (e.g., Herman, 1981, describes three stages), or when clients are in different states (e.g., avoidant vs. intrusive thoughts; Horowitz, 1986). Beutler and Hill (1992) conclude that more knowledge of the effects of therapist behaviors would allow therapists to select specific techniques to use at different points in treatment with sexually abused clients.

Use of Metaphor

Client behavior which may have relevance for the adult survivor population is the use of **metaphor**. Hill and Regan (1991) studied one client who, in the beginning of therapy used the **metaphor** for walls or defenses to describe her need to hide from painful affect. At the end of successful therapy, the client described a little door in her wall. This client also used metaphors as describing different parts of herself (e.g., Jekyll and Hyde). Progress in therapy was noted by corresponding changes in her metaphors. For example, when negative metaphors were discussed in

therapy, the client decreased her use of them. Negative metaphors not discussed in therapy, showed no change over therapy.

Courtois (1988, pp. 207-208) has addressed the use of metaphors with adult survivors, stressing the potential merit of this type of interaction in therapy. If sexually abused clients hide their emotions or communicate them in covert ways, metaphors may provide a means for communication about these secrets.

The Therapeutic Relationship

Gelso and Carter (1985) defined the therapeutic relationship as the emotional alignment which develops between client and therapist. They suggest that this relationship is established and nurtured by a strong emotional bond, agreement on goals, and agreement on tasks. This fostering of the therapeutic relationship may be particularly important for adult survivors because they frequently have significant difficulties in trusting other people. Research is needed to determine whether differences exist in the therapeutic relationship for survivors versus other client groups.

Recent NASW meta-analysis of existing clinical research suggests there is a need for further examination of the nature and effectiveness of the clinical social work relationship (NASW, 1985).

Transference and Countertransference Issues

Transference and countertransference issues within abuse-focused therapy have already been addressed earlier in this literature review.

Methodological Issues in Process Research

Some of the major methodological issues raised by Beutler and Hill (1992) are the following:

(1) Measures should be used that are valid and reliable and have been demonstrated to have efficacy such as Greenberg and Pinsof, (1986) Kiesler, (1973) and Russell, (1987). In selection of measures, good validity and reliability are basic requirements.

(2) When nonparticipant raters are used to rate data, issues of number of raters, rater selection, rater training, rater task, rater bias, and rater drift need to be addressed.

* we recommend using at least two raters on ordinal scales and three raters for nominal scales.

* trained undergraduates can rate highly operationalized variables, whereas more experienced clinicians are required for abstract constructs such as transference. (p. 209)

Conclusion

In conclusion, the literature review in this chapter provided a **context** for understanding the historical developments in the field **of traumatic stress studies**, as well as the synthesis of research and theoretical perspectives related to the consequences of **victimization** in our United States culture. There was a review of the data on the incidence and prevalence of various types of victimizing events such as child abuse, crime, natural disasters and war. Then, there was a review of historical evolution of viewpoints about post-trauma reactions, as well as some discussion on current definitions of post-traumatic stress disorder. This latter section of the study reviewed current pertinent theories of PTSD such as **information processing models of PTSD; schema theory; memory research; Imagery Rescripting** theory and their relevance to Imagery Rescripting treatment. The client context was viewed from a **feminist social work perspective** and a **psychosocial social work perspective** because of the importance of the **relational** aspect of an individual's development (e.g., family of origin, creation and wider cultural context).

Briere's expertise on abuse-focused therapy (1989) highlight the **therapeutic context** and **issues** with adult survivors of childhood abuse.

He emphasized a growth treatment model; one which focuses on the original abuse context and connections of this early trauma to later and current client experiences and behavior. Abuse-centered therapy is highlighted as more focused on client strengths than weaknesses, and proposed transference and countertransference issues pertinent to survivors and therapists. Client-gender issues and dissociation issues were also stressed as relevant to abuse-focused therapy within our victimizing culture.

Kirschners' and Rappaport's research (1993) on the incest survivor syndrome and incestual family types were elaborated on, so as to present a more comprehensive, **contexual understanding of an incest survivor client.**

Finally, Beutler and Hill (1992) described methodological research issues with survivors of childhood sexual abuse regarding input variables; extra therapy events; client variables; therapist verbal response modes; use of metaphor; and the therapeutic relationship. Some specific methodoloigcal issues in process research pertinent to this study were use of valid and reliable measures and rater issues such as number, selection, training, task, bias and rater drift. These methodological issues will be further addressed in Chapter 3.

Summary

The review of literature encompassed the major variables of this study - **Post-traumatic stress disorder; Imagery Rescripting** (nature, evolution, clinical efficacy, pertinent theories, goals, interventions and limitations); the **incest survivor** in her **familial/societal context** and **therapeutic context** of abuse-focused treatment, specifically Imagery Rescripting (IR) therapy. Some expected outcomes of change using (IR) were established regarding the incest-related PTSD women clients such as alleviation of PTSD symptoms; abuse-related schemas changed to more adaptive schemas and enhanced growth in self-calming and self-nurturing techniques.

The two major interventions of Imagery Rescripting are Imaginal Exposure and Imaginal Rescripting, using adult/child nurturing imagery. A controversy connected to the exposure intervention was raised by Meichenbaum (1994) a nationally known expert on PTSD. His evaluative comments supported by other studies confirmed my major concern about possible **retraumatization of the client** with the use of exposure interventions (such as Imaginal Exposure with Imagery Rescripting), even though there is proven success of PTSD symptom reduction.

David Grove (1991) as noted in the literature critique, also had major concerns about retraumatizing clients in the resolution of traumatic memories, especially regarding sexual abuse. His research specifically around this issue, may hold promise for strengthening the Imagery Rescripting treatment model and easing treatment resistance for many survivor clients.

Some new questions raised after the literature critique, are the following:

1) Would David Grove's latest (1991) research on client types and specific matching interventions, give Imagery Rescripting a higher client differential?

2) Would David Grove's specific goal and accompanying interventions on not retraumatizing the client in the treatment process be a strengthening element in the Imagery Rescripting model with survivors?

3) Would David Grove's ultimate non-directive stance as therapist, lower the client resistance to therapy even more and truly present a client-centered model in which clients provide most of the ingredients, knowledge and energy for their own healing?

4) Would John Briere's philosophy (1989) of providing an educational component about our victimizing culture's influence on the client/therapist situation, strengthen the developing treatment model of Imagery Rescripting as a contextual treatment model?

CHAPTER III

METHODOLOGY AND PROCEDURES

The low value placed on process studies by psychotherapy researchers seems to derive from defining investigations of therapy as primarily a study of treatment: To fulfill their scientific mission such studies must address practical issues of cure, accountability and cost-effectiveness.

– *Czogalik and Russell (1994)*

INTRODUCTION

As noted in Chapter 1, the five research questions addressed by this study were:

1) What is the relationship between Imagery Rescripting therapy and effective emotional processing of traumatic incest with adult women survivors?
2) What are the major specific treatment interventions of Imagery Rescripting?
3) What is the structure of the therapist's interactive dialogue and how consistent is it across clients and phases of therapy?
4) How does the resultant structure link therapist participation and Imagery Rescripting's theoretical assumptions and intended sequence?

5) While adhering to the treatment model, what are the client and sequence similarities and how does the therapist participation adjust to client differences and across phases of therapy?

As indicated also in Chapter 1, the research plan to address these questions used both quantitative and qualitative methods. The research design was a multivariate, replicated case study, with repeated measures and P-technique factor analysis. The design incorporated a process approach; an evaluative inquiry; a feminist and psychosocial social work perspective of Imagery Rescripting treatment.

Transcripts from selected videotaped sessions of Imagery Rescripting over the course of treatment were categorized and analyzed for client schema change; therapist interactive structure; consistency of the therapist structure between clients and across phases of therapy; similarities between clients and sequences of treatment; therapist adjustment to client differences and sequences of treatment; client characteristics and client changes.

Data from therapist session forms accompanying the transcribed therapy sessions were quantified and analyzed for client alleviation of PTSD symptoms; vividness of imagery during treatment; levels of distress

experienced by the clients throughout therapy; client difficulty in dealing with perpetrators and rescuing their traumatized child; client growth in self-calming and self-nurturing and change in the quality of flashbacks between and in-sessions, as well as the ability to cope with the traumatic memories.

The process approach for this study of Imagery Rescripting and incest was used, because there is increasing recogniton that empirical process studies are needed to understand and design therapy models such as Imagery Rescripting. For example, Stiles (1988) proposes that progress in establishing "causal" links between process and outcome may require a deeper understanding of the process itself and development of new theories and measures" (p.33). As the question of efficacy is answered by meta-analysis, a new mandate to investigate therapy's little understood processes has emerged (Czogalik and Russell, 1994).

What can we mean by "process"? Kiesler's (1973) normative concept stresses ideas such as activity over time; directional change; and movement toward completion (Greenberg and Pinsolf, 1983, p. 3).

As a complex topic, the exploration of Imagery Rescripting and incest requires a multifaceted conceptual and methodological approach such as in this study. The conceptual complexity of the study was described in Chapters I and II in the discussion of its many theoretical

bases. This chapter will describe the methodological means used to bring relevance and substance to this research, that is, the translation of several theories into a process for answering some social work practice based questions and using techniques for analysis of the therpist's interactive participation in Imagery Rescripting treatment and P-technique factor analysis.

Methodology of the study

Sample

In general, the sample of clients for the study consisted of two women, a primary client and a cross-validating client, selected via availability of videotapes of two participants with Dr. Smucker in the clinical pilot outcome study of Imagery Rescripting. (This study was reported in 1993 at a convention of the Associaiton for Advancement of Behavior Therapy, but it has not yet been published). (See chapter II for further results of the outcome study).

Client 1 was a middle-aged married woman of eighteen years with a man who was physically and emotionally abusive with her and their four chidlren - daughters ages 18, 16 and 6 and a four-year old son. During the time of Imagery Rescripting treatment, "Dolly" was also enrolled in an

incest therapy group; couples therapy; individual therapy and protective services. She had a diagnosis of post-traumatic stress disorder at pre-treatment. (No other data on further diagnosis was available for the researcher, however, clinically Dolly seemed to be more anxious than depressed and she definitely, did not seem to be psychotic). Dolly suffered at least six years of forced sexual abuse by her father from ages six to twelve, with associated fearful circumstances, such as threats of causing a car accident with her non-compliance and being hung by her ankles in the basement during sexual abuse. She was tortured by intrusive memories and a recurring nightmare for about twenty-five years (which was the actual rape at age 12, after about six years of prior incestual abuse). Dolly appeared highly motivated for Imagery Rescripting therapy and consistently did her homework.

Client 2 was a young adult age 26, who was married several years to an "understanding" man regarding her incest experiences, but who did not want to know the details or even of her work in therapy. "Kathy" had been in treatment before Imagery Rescripting, regarding her alcohol dependency and hospitalization for depression and suicidality. She too, had a diagnosis of post-traumatic stress disorder at pre-treatment. Kathy suffered incest by multiple perpetrators as she was growing up. She was not physically forced

to comply with her step-father's and three brothers' sexual gratification, but she accepted bribes for sexual favors and she experienced pleasure with the sexual encounters with her step-father. Kathy struggled with chronic guilt and shame for "choosing" to have sex with her family membrs. Kathy had intrusive memories, recurring nightmares, chronic depression, struggles with rage, intimacy problems and sexual dysfunction.

As is evident, the sample was purposive and retrospective. The focus on the selection process involved having videotapes of PTSD-related incest women clients using Imagery Rescripting therapy by the originator and senior therapist of the new treatment model. The outcome study used random selection, but this study did not, as it addressed the relationship between Imagery Rescripting therapy and incested women.

Legal and ethical implications regarding the use of human subjects in research are understood and safeguards were implemented to protect confidentiality of individuals, such as, the use of case numbers rather than participant names in data analysis and the use of pseudonyms rather than the names in reporting results. Approval for the project was secured from the Institutional review Board for the Protection of Human Subjects, Research Service Office, Loyola University of Chicago in November, 1995.

Setting

The study was conducted in the midwestern city of Milwaukee, Wisconsin. The city's conservative religious and political roots, as well as economic base are rapidly changing. The city's strong ethnic diversity is not represented in the sample. The psychiatric hospital which provides both inpatient and outpatient mental health services tends to service those who are in the middle class and upper class with acceptable insurance and/or the ability to pay. The hospital and Cognitive Therapy Institute have many professionals who are simultaneously on the teaching staff of the Medical College of Wisconsin. This teaching hospital has been especially innovative in expanding specialized services for psychologically traumatized people; education for clinicians and researchers in the area of cognitive and behavioral therapy, post-traumatic stress disorder and treatment, and innovative treatment for survivors of childhood sexual abuse. Dr. Smucker, following the encouraging results of the pilot study of Imagery Rescripting, and the very well received Imagery Rescripting Workshops at the 1992 World Congress of Cognitive Therapy in Toronto, Canada and the 1993 European Association of Behavior and Cognitive Therapies in London, began receiving invitations from hospitals, clinics, and mental health associations in the United States and abroad to conduct

Imagery Rescripting training workshops. Thus in 1993, Dr. Smucker began accepting invitations for clinical training in seminars/workshops in Imagery Rescripting in the United States and Europe. Many workshop participants have been and continue to be Social Workers seeking effective and cost-effective methods and strategies to cure and reduce intrusive PTSD symptoms and change abuse-related effects, specifically **schemas** which hinder survivor clients from quality of life and daily effective functioning in their environments of family, work, school and wider society.

Instruments

Three instruments were used in the project. They are:

(a) the Stuttgart Interactional Category System (SICS);

(b) A Therapist Session Form; and

(c) Imagery Rescripting: A Treatment Manual for Adult Survivors of Childhood Sexual Abuse (1966). (see **Appendix A** for a sample of the first instrument used and **Appendix B** for a full copy of the Original Therapist Therapy Session Form (1992).

Stuttgart Interactional Category System/2 (SICS)

The Stuttgart Interactional Category System/2 (SICS) (Czogalik and Mauthe, 1987) provides a multiperspective assessment of verbal behavior.

Five perspectives are used to code each utterance: **Mode of Involvement**, assessing aspects of the affective/cognitive engagement of the speaker; **Mode of Conversational Techniques**, assessing the type of speech action carried out by the speaker's utterance; **Mode of Conversational Regulation**, assessing the degree and type of linkage used to chain utterances; **Mode of Thematic Concern**, assessing the central themes in the utterance; and **Mode of Temporal Orientation**, assessing the temporal focus of the utterance. An utterance that is classified as only an Interpretation in most verbal response mode systems (e.g. Elliott, Hill, Stiles, Friedlander, Mahrer and Margison, 1987) is considered from four other perspectives simultaneously. For example, the interpretation can also serve to continue a topic of discussion (i.e., under the mode of conversational regulation), to embed the topic in an emotional frame (i.e., under the mode of conversational involvement), to be focused on the therapist-client relationship (i.e., under the mode of thematic concern), and to concern events in the present (i.e., under the mode of temporal orientation). In the SICS system an utterance is defined as everything speaker A says between the previous and subsequent utterance of speaker B (Czogalik and Russel, 1994).

Many authors have described therapist and client verbal behavior in therapy such as Hill, C (1986); Hill et al (1988) and Stiles, L. (1979). Czogalik (1989) concurrently assesses multiple dimensions of verbal behavior as a way of capturing the **general participatory structures of therapeutic discourse**. These multidimensional styles of participation are conceived as observable behavioral patterns, that is, as stable and repetitive patterns of discourse which can vary **quantitatively**, and I would add, **qualitatively** depending on situational and intentional cues. Such variations are not expected to be random but to create meaningful configurations or patterns of participation and interaction over time (Czogalik and Russell, 1994; 1995 and this study of 1996).

Since at least 1987, Czogalik and Mauthe have been developing the (SICS) instrument. Czogalik (1993) has described a research program in Germany and the United States that attempts to grapple with **process**, when conceptualized as a form of "human dyadic communication in an interpersonal framework" (Kiesler, 1973, p. 3). The assumptioin is that meaning is created by mutual negotiations on a moment-to-moment basis within the **context of interpersonal relationships**. Such negotiations are multilayered and occur simultaneously across a variety of channels. They relate to, in the deepest sense, the preservation of personal integrity and

social belongingness. From the very beginning, persons behave as directed toward achieving these goals. For example, in the Mother infant dyad, one observes efforts at achieving interactiional attunement that subserves both attachment needs and the growth of a sense of autonomous agenthood (Stern, 1985). Such attunement requires the "reading" of others, as well as the "inscribing" of oneself in communicative behaviors. The combination of common and individual reading and inscribing processes defines as individual's or group's interaction participation style. For adults, the key phenomenon that is read and is inscribed is **language** or **discourse.** For example, Czogalik studied intensely the discourse regulators, speech acts, markers of types and levels of discourse involvement, as well as temporal orientation and semantic content and their relationship to adaptation. He believed this research was useful for understanding human discourse in general, and recommended it for use in explicating psychotherapy as well. Then in collaboration with Dr. Robert Russell, the psychology department at Loyola University, Chicago, developed a code book for criteria to further develop the (SICS) instrument's **validity** and **reliability**. The code book has not been published and was not available to this investigator at the time of this study, but because of Czogalik's rationale for developing the instrument

and his latest research (1993; 1994; and 1995), I chose to use the (SICS) instrument without the benefits of the further development of its **reliability** and **validity**.

Therapist Therapy Session Form

To guide both the quantitative and qualitative phases of this study, the Therapist Therapy Session Form was used to collect and analyze data concerning client and therapist compliance, problems and successes of the Imagery Rescripting treatment model and client change.

In addition to the tape-recorded session transcripts, these forms completed by Dr. Smucker during and after each interview session (three sessions per client) were used. These detail the therapeutic process, with special emphasis on the clients' affective states, the data for analyzing client growth and difficulty with the treatment and the therapist's information considered important during that particular session.

Current Treatment Manual of Imagery Rescripting

The current treatment manual of Imagery Rescripting entitled Imagery Rescripting: A Treatment Manual for Adult Survivors of Childhood Sexual Abuse (Smucker, Dancu, Foa, and Niederee, 1996) was used as a

measuring tool of Imagery Rescripting in this study. This is an updated version of the unpublished manuscript Manual for the Treatment of Adult Survivors of Childhood Sexual Abuse Suffering From Post-Traumatic Stress (Smucker, Dancu, and Foa, 1991).

Procedures

The Pilot Project

Prior to launching the full study, a pilot project was conducted. A rating chart was designed (See **Appendix C**) for use with the Stuttgart Interactional Category System/2 (Czogalik and Russell, 1994) tailored to this project. Through hours of practice coding on transcripts, the chart was designed and color-coded to include the five major classifications of therapist's utterances with its 41 categories defined and exemplified. There was an accompanying **Code Book** developed with the Coding Chart. Further development of the Coding material was done in the training process with Rater 2. (See section on procedures.)

Selection and Training of Raters

Rater 1 was the research investigator because of her familiarity with the Imagery Rescripting treatment of Dr. Smucker and her graduate studies (masters and doctoral level in clinical social work), her 20 years clinical experience and her in-depth study of **trauma** with special populations like survivors of childhood sexual abuse, with an emphasis on **incest**. Rater 2 was also a clinical social worker, of about 16 years and specializing in trauma, and with a familiarity with Dr. Smucker's treatment model through education and training classes.

Rater 2's professional status is that of a bachelor level social worker with Wisconsin Certification in alcohol and drug treatment. She is in the process of obtaining certification in trauma counseling and completing her masters in Social Work. One of the important criteria for selecting Rater 2, besides her status as an experienced social worker and familiarity with trauma, special populations of trauma and Smucker's treatment model, was her ability to commit to the project in spite of busy schedules and the tedium resulting from the meticulous, fine-grained coding process of many hours of work.

Initial training for Rater 2 included an orientation of several hours in which the research project and specific (SICS') piece were explained and

illustrated with accompanying **color coded chart, code book** and the packet of six videotaped transcripts (3 per client) of the therapeutic interview. Some practice transcripts were done together and independent work was assigned before the next working session.

Training, as suggested by Clara Hill (1986), essentially entails familiarization with the coding system and then, practice and discussion on transcripts until the judges or raters are able to reach consensus with each other on decisions based on the criteria of the coding system and task. The intent is that the system remains **consistent** or **reliable** across raters. The training was expected to continue until there was at least 75-80% agreement on all of the categorizations, which usually requires about 20 hours.

In this study, 20 hours of training was the minimum of training. At least 40 hours were spent in training and a 90% agreement level was reached between raters. Rater 1, did have the advantage of having viewed all the videotapes of the therapy sessions, whereas Rater 2, did not have the time to do this observation. During the training process, Rater 2 was encouraged to express any diverse views and to freely challenge Rater 1's decisions within the system so that the system remained consistent across raters.

Rating Procedures

Raters catgorized statements on transcripts independently using the code book and then shared their decisions at a meeting. The working atmosphere of the meeting was one of respecting challenge and difference, along with one's rationale for the coding and movement toward consensus without undue influence of each other.

After the instruments were scored, and the data was compiled and quantified, **analysis** of the therapist's interactive participation was done. Therapeutic text analysis was used to glean **schema changes** of clients over the course of therapy. Text analysis of client similarities, as well as differences, linked to therapist participation was also done. In addition, context analysis was employed to trace the client growth and change regarding self-nurturance and self-calm (a difficulty characteristic of adults sexually abused in childhood). Finally, content analysis was used to examine the link of therapist participation to Imagery Rescripting's theoretical assumptions and intended sequence. This **qualitative analysis** was reviewed by Rater 2. No substantive additions were recommended by Rater 2.

P-technique

Measurement procedures can capture both stable and changing patterns of variables across time. One of these procedures - the **P-technique** - was introduced almost 45 years ago by Cattell (1951), and applied to therapy by Luborsky (1953; see Cattell and Luborsky, 1950) to describe both stable and changing characteristics of client involvement in therapy. It requires many measurements on the same subject scoring the unit across repeated occasions. Correlations between measurements over the repeated occasions are **factor analyzed**, resulting in *process factors*. P-technique has been applied in only a few psychotherapy studies (e.g., Mintz and Luborsky, 1970; Dahl, 1972; Mook, 1982a; 1982b; Czogalik and Hettinger, 1988; Hentschel, Kiessling, Heck and Willoweit, 1992; Czogalik, 1993).

Essentially, the P-technique has been used (1) to describe the qualitative structure of an individual client's or therapist's participation in the therapeutic process (Mintz and Luborsky, 1970), and (2) to assess quantitative changes in this structure across sessions for a therapist or a client (Mintz and Luborsky, 1970), or a pair of therapists or clients or dyad (Dahl, 1972; Mook, 1982a, 1982b). These pioneering studies were neither incorporated into the field nor developed.

But also some limitations according to Czogalik and Russell (1994), must be stated regarding these applications. The first limitation has to do with the data to which P-technique was applied. In most studies, the categories used to code therapist behavior related to technique, nonspecific factors, symptoms, grammatical categories, or a narrow band of content categories. However, there were few categories in most of the applications to this early analytic theory (e.g., in Mintz and Luborsky 1970, there were only nine therapist categories). Moreover, the categories were derived from a single perspective - basically from a surface description of clinical techniques, now called verbal response modes (Stiles, 1978), The categories did not derive from a general consideration of the structure and process of human interaction, as suggested by Kiesler.

The second limitation has to do with requirements for P-technique. Because P-technique involved the repeated measurement of many variables on the same subject response unit, many such units are needed for satisfactory factor reliabilities and statistics. Some early studies had as few as 60 response units, each coded in terms of 18 categories. Other studies with better response to variable ratios did not conduct reliability assessments at the factor level (Mook, 1982a; 1982b). None of these early studies applied tests to estimate factor stability. Without stability, there is

no assurance that the structures persist across the sample, and this is necessary for determining real quantitative variation.

The third limitation pertains to the fact that there are real autodependencies in discourse, in fact, theoretically, the units of discourse cannot be conceived as independent. However, statistical and real dependencies can be conflated in troublesome ways in the correlation matrix and the resulting factor structure. These early studies did not attempt to address the question of the influence of real and statistical autodependencies and their impact on results. This situation is currently being addressed and there are some procedures that try to handle this vexing limitation (e.g., Molenaar, 1985).

Another shortcoming pertains to a focus on one or two therapists in one or two sessions. None of the studies in 1994 compared therapist structures of participation quantitatively or investigated therapist by phase interactions. (Czogalik and Russell, 1995, did do such a study). Only one study (Dahl, 1972) used P-technique to "discover" naturally occurring phases in the therapist's involvement via chronographic analysis. Especially this last possibility is a significant contribution of the P-technique that needs further study.

Research Hypotheses

The five research questions of this study (See the introduction to this chapter.) were collapsed into the following five research hypotheses:

Hypothesis 1: There is a positive relationship between Imagery Rescripting therapy and effective emotional processing of traumatic incest with adult women survivors.

Hypothesis 2: Imagery Rescripting contains two specific treatment interventions (i.e., imaginal exposure and imaginal rescripting) which effectively process traumatic incest over a short period of time.

Hypothesis 3: The variance in the therapist's interactive dialogue will result in a certain structure which is consistent across clients, but not consistent across phases of therapy.

Hypothesis 4: This resultant structure will llink the therapist's participation and Imagery Rescripting's theoretical assumptions and intended sequence.

Hypothesis 5: Adhering to the treatment model, the therapist's participation will demonstrate client and sequence similarities, as well as differences.

Data Analysis and Interpretation

A variety of descriptive and inferential statistics were used in the analysis of questions and hypotheses and in the interpretation of the information collected in the study. Descriptive statistics were used to describe the variance in the therapist's interactive discourse.

Inferential statistics were used to discover the structure of the variance in the therapist's interactive discourse and to compute the consistency across clients and across phases of therapy.

Data analysis comprises both qualitative judgments and quantitative assessments of all results: That is, it addresses both questions: "Are the results statistically significant," as well as, the questions, "Do the results have practical significance for clinical social workers and social work educators?"

To answer the first and second research questions, correlations between specific treatment interventions of Imagery Rescripting and

change measured at repeated intervals during therapy, were analyzed and reported.

To answer the third question, inferential statistics were used, highlighting the P-technique and factor analysis and Cronbach's ALPHA for reliability between clients and post hoc tests between groups.

Answering the fourth and fifth questions was related to interpreting the practical significance of the quantitative results; comparing the therapist participation structure and text analysis with the Imagery Rescripting theoretical assumptions and intended sequence as measured by the current treatment manual; and using the text to analyze the therapist participation with client and sequence similarities. In addition, text analysis was used to discover how the therapist's participation adapts to the client and sequence differences.

CHAPTER IV

FINDINGS OF THE STUDY

The empirical study of adult survivors is a newly emerging field. By merging methodological sophistication with theoretical sophistication in the victimization literature, true progress can be made in the development of effective and (cost-effective) treatment programs.

– Beutler and Hill, 1992

INTRODUCTION

The findings of this study were generated in two distinct time periods. In the first phase or **quantitative phase** the therapist interactive participation in the Imagery Rescripting was analyzed at the utterance level. The therapist's utterances (N = 762) were rated on 41 categories of the Stuttgart Interactional Category System/2 in two beginning, two middle, and two ending sessions, providing a primary and a cross-validation sample. Application of the **P-technique** revealed one stable and reliable therapist participatory factor, (i.e., Directing insightful/painful work), accounting for 67% of the total variance.

The second or **qualitative phase** yielded narrative data from the analysis of both the therapist and the client and data from the accompanying Therapist Session Form of a primary client dialogue and a cross-validating client. A current treatment manual was also used as a measuring tool.

Section One: Quantitative Findings

The quantitative portion of this study focused upon the structure of the therapist interactive participation in using Imagery Rescripting treatment. Forty-one types of therapist variables were of particular interest, providing a five perspective assessment of the therapist's verbal behavior (see Appendix A), and the combined score of two raters using the (SICS) instrument. The videotaped 2 participants
in the study composed a convenience sample, which was available to the investigator for analysis. Since the sample was obtained in a non-random manner, the ability to generalize to the entire population of adult women survivors of traumatic incest is limited. Having a limited client demographic profile essentially dependent on the interview analysis, provides some general information which can be used in extrapolating these findings to other groups of PTSD-related female incest survivors in psychotherapy.

Scores on the (SICS) Scale

In the **P-technique factor analysis** process the combined coding scores of Rater 1 and Rater 2 were computed for both Client 1 and Client 2 on the forty-one variables of the therapist's interactive participation. (See the color-coded chart on the Stuttgart Interactional Category System/2 (SICS) in Appendix C for a listing of the therapist's variables). Then, in Table 4.1, match the therapist's variable listed in column 1 of the table for each client with the categories on the (SICS) chart to interpret the data in the table. Note that there are several therapist variables of the forty-one categories which are missing under each client. These categories or variables were not used in the coding process by the raters. For example, therapist variable 1 (VI) in Table 4.1 is **Positive Evaluation** (A positive value judgment by the therapist), which was listed for each client.

Descriptive statistics such as the **mean** and **standard deviation** for each therapist variable for both clients are listed in Table 4.1. For example, Client 2 received more positive evaluations by the therapist's verbal responses than Client 1.

Table 4.1 **Comparative List of Therapist Variables on the (SICS) With Deletion of Variables With Missing Values Through Therapy**

Client 1			Client 2		
Therapist Variable	Mean	Standard Deviation	Therapist Variable	Mean	Standard Deviation
V1	6.00	2.64	V1	10.00	4.58
V2	2.00	1.00	V2	2.33	3.21
V3	2.00	1.00	V3	.66	.57
V4	2.00	1.00	V4	.66	.57
V5	4.33	1.52	V5	7.66	5.03
V6	10.66	4.93	V6	9.16	7.48
V7	21.66	5.68	V7	7.33	5.50
V8	33.00	17.08	V8	32.33	7.23
V9	28.00	15.58	V9	28.00	.86
V10	2.33	2.51	V10	4.00	2.00
V11	3.50	1.32	V11	2.50	2.17
V12	10.33	9.50	V12	5.33	1.52
			V13	.66	1.15
V14	27.33	12.05	V14	26.66	10.53
V15	4.66	2.08	V15	4.83	1.25
V16	50.33	11.93	V16	32.33	13.65
V17	23.33	9.29	V17	8.33	5.68
V18	60.66	7.23	V18	7.00	2.64
V19	17.00	10.81	V19	14.00	5.29
V21	11.33	7.76			
V22	.66	1.15	V21	11.66	2.88
V23	64.66	34.58	V22	1.33	1.89
V24	24.33	15.30	V23	74.33	17.00
V25	23.33	9.23	V24	14.66	1.52
V26	5.33	1.52	V25	10.33	2.88
V27	23.00	10.14	V26	8.00	5.29
V28	75.16	37.65	V27	37.33	8.62
V29	25.33	16.65	V28	59.33	18.44
V30	21.00	7.93	V29	21.33	7.37
V31	25.00	14.10	V30	9.00	3.46
			V31	26.33	9.07
V33	43.00	21.63	V32	1.66	1.15
V34	2.66	3.78	V33	50.00	18.33
			V34	5.66	4.16
V36	2.33	4.04	V35	1.00	1.73
V37	1.33	.57	V36	5.33	9.23
V38	11.00	10.39	V37	.66	.57
V39	17.66	14.15	V38	14.66	2.08
V40	1.33	1.15	V39	12.33	1.52
V41	20.66	7.23	V40	1.33	1.52
			V41	7.33	5.50

Note: The dark blanks indicate the missing therapist variables which did not apply in the coding process.

The scores on the SICS for both Client 1 and Client 2 are noted with the **frequencies** of each therapist participatory category listed in table 4.2.

For example, the therapist variable of the **person of the client** was coded by both raters as the most frequent and stable therapist characteristic to appear in the therapist discourse for both clients (Client 1, 258 times, and Client 2, 300 times). This indicates that, the therapist is concerned about the person of the client and that Imagery Rescripting is client-centered as presented. On the other hand, going down the rank-ordered list of therapist variables, the most changing therapist variable for Client 1 was, **disaffirming**, occurring 4 times throughout therapy. According to the raters within their criteria, and the text the therapist "negated, ignored or generally did not support the client's preceding utterance." For Client 2, the category of **neutral description** was rated 4 times throughout therapy, meaning that "a description is given and it is neutral. This may have been done to facilitate Client 2's mode of involvement, since she was more dependent on the therapist for verbal expression, than Client 1. (Table 4.2 will be used in greater detail in response to the last hypothesis regarding therapist participation and client similarities and differences).

Table 4.2: **Rank Order of Therapist Variables on the Stuttgart Interactional Category System/2 (SICS) Items Throughout Therapy**

Client 1		Client 2	
Stable and Changing Therapist Variables	**Frequency**	**Stable and Changing Therapist Variables**	**Frequency**
Person of the Client	258	Person of the Client	300
Informing	168	Informing	168
Answering	146	Directing	84
Minimal Verbal Regulation	133	Affirming	70
Content less Words	124	Minimal Verbal Regulation	62
Significant others / Client Relationship	106	Positive Evaluation	60
Directing	102	Lack of Temporality	54
Therapist / Client Relationship	66	Distant Past	48
Cognitive Appraisal	56	Positive Affect	46
Initiating	40	Confronting	32
Distant Past	32	Work / Leisure	32
Neutral Description	12	Comprehending	29
Objective Events	8	Person of Therapist	10
Non-Significant Others / Client Relationships	8	Non-significant others	6
Disaffirming	4	Objective Events	4
		Disclosing	4
		Neutral Description	4

Consistency of Therapist Factor Structure Across Clients and Phases of Therapy

The findings presented in this section address the research questions and hypotheses. First, **Question Three: What is the structure of the therapist dialogue and how consistent is it across clients and phases of therapy?**

It was predicted that the variance in the therapist's dialogue would result in a certain structure which is consistent across clients, but not across phases of therapy. For the purposes of this study therapist participation was measured by the total factored score on the Stuttgart Interactional Category System/2. From the study question above the following hypothesis was derived to more closely examine the relationship of the therapist factor structure between clients and between phases of therapy.

Hypothesis 3: The variance in the therapist dialogue will result in a certain structure which is consistent across clients, but not across phases of therapy.

Hypothesis 3 was supported on all three predictions (i.e., a therapist structure was factored out and named; this structure was consistent across clients; but the structure of the therapist participation did differ across phases of therapy).

In the first prediction, using the P-technique and factor analysis, only one factor was obtained from the 41 therapist's participation variables. It was expected that the surface variability in the therapist speech would be explained by at least a few general components or factors and that these general factors would map onto central elements in the model of therapy process. By "general" I mean that the factors comprising the structure of therapist participation would be evident across different phases of therapy and different clients. However, by calculating the factor scores, the moment-by-moment level of the participation structures would then, be assessed and compared - these variables might not be "general," and might vary with client, phase of therapy and psychological episode (Czogalik and Russell, 1994). Only one factor resulted, and the process stopped. The result of only one factor might have happened because of chance or the limitations of the P-technique as indicated in Czogalik and Russell's research, (1994). (See Chapter III on the limitations of the P-technique). The specific shortcoming concerns a focus on only one therapist, even though the study concentrates on two clients and across three phases of therapy. However, Dr. Russell thought it should be a good test of P-technique with one therapist, a replicated case study, and three phases of therapy. Another possible reason for having only one factor

might be **rater bias**. The rater selection, training, and task conditions were cited in Chapter III, and seemed to take precautions for **validity and reliability**. Another possible reason for only one factor might be the rater's nonuse of every therapist category on the SICS instrument per client. However, if the therapist category was judged not applicable by the raters, why would the category be used anyway? Another possible reason for only one general factor resulting, might be that the Imagery Rescripting Model's elemental structure as performed by the therapist, consists mainly of one specific factor structure **of "directing insightful/painful therapeutic work."** This latter reason I believe answers why only one factor structure of the therapist participation, resulted.

Continuing on with Hypothesis 3, the resulting factor structure was **consistent between clients**. Cronbach's ALPHA, a reliability statistic, commonly used for measuring reliability of an instrument, was computed. Essentially, the statistical formula examines all of the possible correlation between scores within the scale. The score for Cronbach's ALPHA can range from zero to one. A coefficient of .80 > is considered to be a good measure of reliability in a scale or instrument. For purposes of this study, Cronbach's ALPHA was used to compute the reliability analysis of the scale (overall) for each Client.

For Client 1, out of a possible 41 items on the SICS instrument, 37 items were computed with a standardized item ALPHA = .9497 and a Cronbach's ALPHA of .9569.

For Client 2, out of a possible 41 items on the SICS instrument, 40 items were computed with a standardized item ALPHA = .9055 and a Cronbach's ALPHA of .9292. Therefore, with a Cronbach's ALPHA of >.80 as noted previously in this section, for both clients, there is a good measure of reliability in the instrument for both clients. Thus, back to supporting Hypothesis 1A, the factor structure is **consistent between clients**.

Finally, in support of the last portion of Hypothesis 3. (Is the factor structure consistent across phases of therapy?), the **Tukey's HSD test, one of the post hoc comparisons was used.** In short, post hoc tests protect us from making too many Type I errors by requiring a larger difference (between sample means) before we can declare that difference to be statistically significant.

There are several commonly used post hoc tests. The only real difference among them is that some are more conservative than others. In ascending levels of conservativeness with regard to Type I errors (but descending power), we could choose from among such tests as Duncan's

multiple-range test, the Newman Keuls tests, Tukey's HSD test, or the Scheffé test. To use any one of these tests our rating must first be significant.

The **Tukey's HSD test** (HSD stands for "honestly significant difference") was selected to test the consistency of the therapist structure across phases of therapy. The hypothesis of the equal population means is rejected for any pair of samples for which the difference between the $\bar{x}$'s is a large as, or larger than the critical HSD value. Thus, in the repeated measure design for Client 1, the difference between $\bar{x}$ (between the beginning and ending therapy phase) was 12, which was greater than the HSD value of 5.07. Therefore, there was a significant difference with the therapist factor structure between the phases of beginning and ending therapy. Likewise, the difference between $\bar{x}$(between the beginning and middle phase of therapy) was 12, which was greater than the value of 5.07. Therefore, there was also a significant difference with the therapist factor structure between the phases of beginning and middle therapy.

In the repeated measure design for Client 2, the difference between the $\bar{x}$ (between the beginning and ending therapy phase) was 7, which was greater than the HSD value of 3.60. Therefore, there was a significant difference with the therapist factor structure and between beginning and ending therapy. The difference between the $\bar{x}$ (between the beginning

and middle therapy phase) for client 2 was 4, which was greater than the HSD value of 3.60. Therefore, there was significant difference with the therapist factor structure and between the beginning and middle phases of therapy.

The therapist's participation structure with both clients differed in the beginning and ending phases of therapy, and also differed in the beginning and middle phases of therapy. According to the treatment of Imagery Rescripting, the major two specific interventions, (as measured by the current treatment manual) are theoretically and functionally structured differently (Development of this idea will be addressed further in this chapter).

Summary of Quantitative Findings

During the quantitative phase of this study the therapist's interactive participation of Imagery Rescripting was analyzed at the utterance level. The therapist's utterances (N = 762) were rated on 41 categories of the Stuttgart Interactional Category System/2 in two beginning, two middle, and two ending sessions, providing a primary and a cross-validation sample. (In the SICS system an utterance is defined as everything speaker A says between the previous and subseqeunt utterance of speaker B).

Application of the utterance of P-technique revealed one stable and reliable therapist participatory factor which was named - **Directing insightful/ painful work**. This named factor accounted for 67% of the total variance of the 41 therapist categories on the SICS instrument.

It was expected that several factors would map onto central elements in the Imagery Rscripting process. Then, these factor scores would be assessed and compared (Czogalik and Russel, 1994). However, as indicated earlier, only one factor emerged and the factoring process stopped. This result may have occurred because of change; the limitations of the P-technique (see Chapter III on the limitations of the P-technique.); rater bias; the rater's nonuse of every therapist category on the SICS instrument per client, or the fact that Imagery Rescripting's essential elemental structure as performed by the therapist, consists of **"directing insightful/painful therapeutic work."** Based on the study of the (IR) treatment model, and Czogalik and Russel's research (1994). I believe that either the limitations of the P-technique or the single-purposeness of the very nature of Imagery Rescripting (developed at this point in time) or a combination of these reasons may have contributed to the results of the factoring process in this study.

This resultant factor structure of the therapist participation was not found to be consistent across phases of therapy. In fact, there was a significant difference between the beginning and ending phases of therapy and between the beginning and middle phases of therapy with both clients. The Tukey's HSD (Honestly Significant Difference) test was used to compute the significance. (see Table 4.3 and text pp. 124-125 for the findings and explanations.)

Table 4.3: **Quantitative Findings Regarding Hypothesis 3 - One Factor From (SICS) — Categories; Consistency Between Clients and Variance Across Phases of Therapy**

	Therapist Categories	Significance	Reliability	Consistency Throughout Therapy - Use of Tukey's HSD Test			
				HSD Value	Difference Between $\bar{x}$	Difference of Beginning and Ending Therapy	Difference of Beginning and Middle Therapy
Client 1	One factor - 37 of 41 items on (SICS) chart (see Appendix C and Table 4.1).	ALPHA = .9497	Cronbach's ALPHA = .9569	5.07	12	✓	
				5.07	12		✓
Client 2	One factor - 40 of 41 items on (SICS) chart (see Appendix C and Table	ALPHA = .9055	Cronbach's ALPHA = .9292	3.60	7	✓	
				3.60	4		✓

Note: Factor 1 = Directing Insightful / Painful Work

Section Two: Qualitative Findings

The findings about the relationship between Imagery Rescripting and the effective emotional processing of trauma, as indicated in hypothesis I, will be addressed in this section under the headings of vividness of client imagery; client distress levels; client difficulty in dealing with the perpetrator; client capacity for self-calm and self-nurture; client use of adult/child imagery; flash-backs between sessions, and client schema changes throughout selected representations of beginning, middle and ending therapy with (IR) therapy.

Effective emotional processing can be gauged, according to Horowitz (1979, 1986) and Rachman (1980) from the persons' lack of distress connected to trauma and positive change from abuse-related schemas. (Mc Cann et al 1988, Resick, Schnicke and Smucker 1992, 1993 and Smucker et al 1995, 1996) proposes that Imagery Rescripting therapy, with its interventions of imaginal exposure and imaginal rescripting with the use of adult/child imagery does reduce the symptoms of post-traumatic stress disorders (and eventually eliminate them) which arises because of an ineffective processing of traumatic incest. Likewise, the authors propose that abuse-related schemas such as helplessness can be changed to more adaptive schema such as empowerment (see Figure3).

It was predicted that there would be a positive relationship between Imagery Rescripting therapy and effective emotional processing of traumatic incest with adult women survivors. Besides the theoretical support in the literature review, the findings of this particular study did support Hypothesis 1.

Both clients at post-treatment no longer had a diagnosis of post-traumatic stress disorder according to the DSM-IV criteria. In addition their PTSD symptoms of reexperiencing the trauma in recurrent memories, dreams, flashbacks or heightened physiological response was alleviated; the emotional numbing and continued avoidance of similarities to the traumatic event(s) was reduced and symptoms of increased arousal like sleep disturbance were alleviated. Now, let us move on to the qualitative findings of the positive relationship between Imagery Rescripting therapy and effective emotional processing of traumatic incest.

Vividness of Client Imagery

Within the **imaginal exposure** part of treatment, the client accesses the traumatic memory "network" and so the quality of vividness of their imagery is important so as to assess how "in touch" with the traumatic memories the client is. Then, the client is more able to reexperience the original trauma, with the feelings, thoughts and bodily sensations. The data for all but the last graph were extracted from the Therapist Session Forum. These data provided a repeated measures design to capture client change. The graph in (Figure 4) shows the vividness of Imagery of Client 1 and Client 2 throughout therapy.

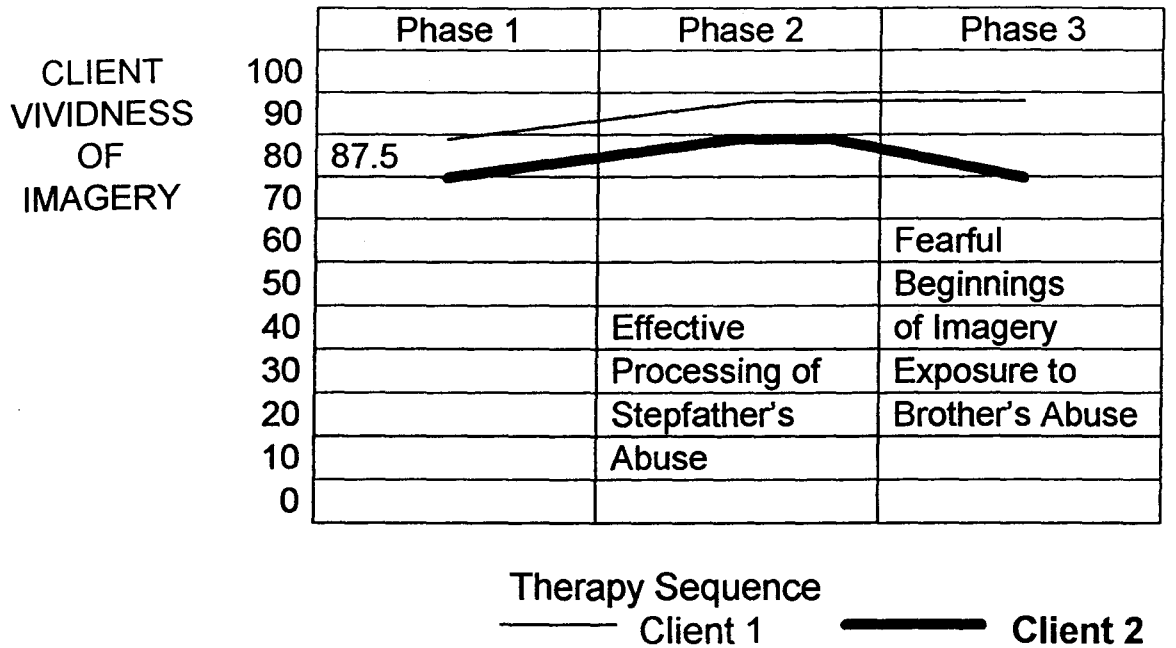

Figure 4: Comparative Scores of Client Vividness of Imagery Throughout Therapy

Note: Client 2 does effective processing of her stepfather's abuse in phase 2 of therapy and according to her need, just begins exposure imagery concerning her brother's abuse in phase 3, whereas phase 3 is routinely used only with self-nurturing imagery.

Both clients were able to focus in on the imagery of the abuse scene quite well, and improve with practice, with Client 1 having a higher quality of vividness of imagery. Client 1 was imagining the abuse scene in a moving car by her perpetrator father, which was done with great force when she was

age 6. Client 2 was imagining the abuse scene first by her perpetrator stepfather and afterwards, her perpetrator brothers, when she (around middle school years) was give a "choice" by her perpetrators to come into their rooms. For client 2, there was extreme fear in beginning to imagine the abuse by her brothers towards the end of therapy, whereas the processing of the abuse by her stepfather would have been similar to Client 1's progress on the graph.

Levels of Distress Experienced by Clients Through Therapy

In the imagining of the abuse scene, the client began, as in a trance, to re-experience the original trauma with its associated affect. The graph traces the distressful feelings of Client 1 within five-minute intervals throughout the therapy (See Figure 5).

The graph associated with Client 2 shows her distressful feelings within ten-minute intervals throughout the therapy (See Figure 6). The therapist likely measured Client 1's level of distress more often because there was a greater variance in her "working through" the distressful emotions, than Client 2. The standard rate of checking on the (SUDS) scale is ten minute intervals. The therapist had not completed the therapist Session Form on the Imagery Rescripting aspect of therapy with Client 2, so

the investigator completed the graph from data taken from the text of the therapeutic discourse.

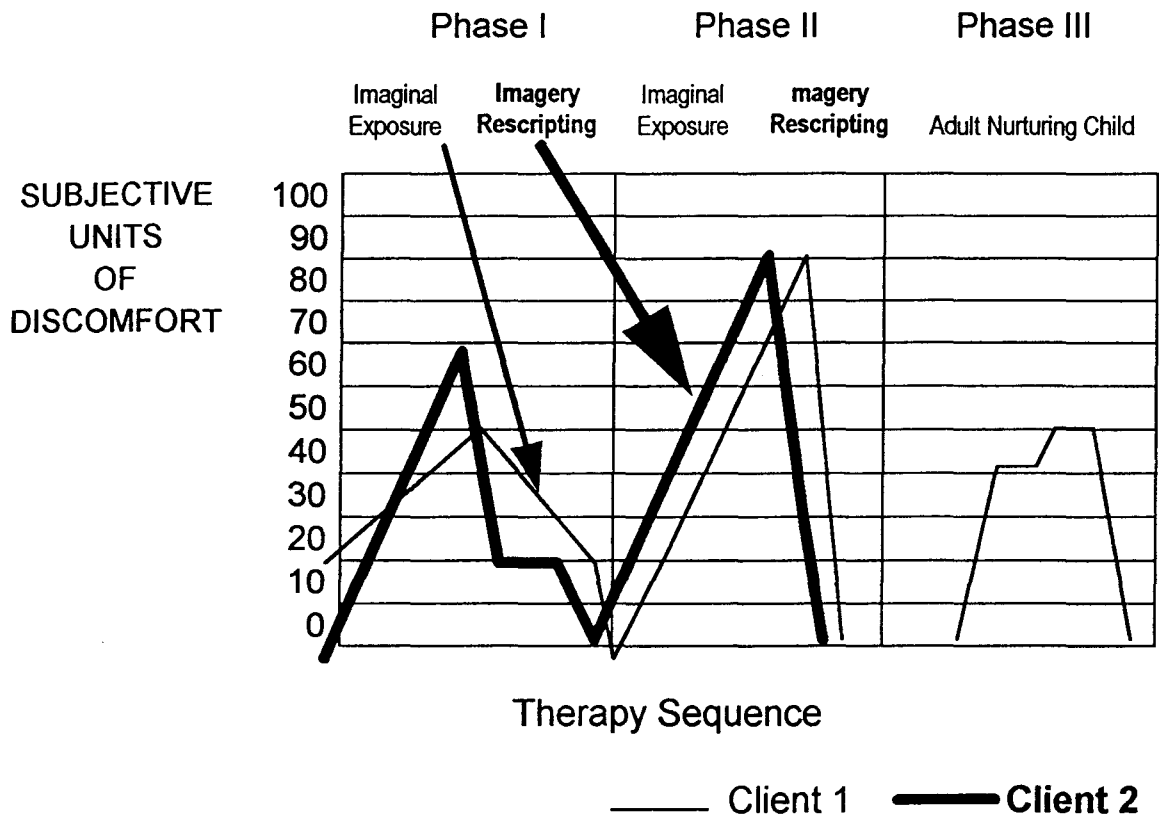

Figure 5: (SUDS) Level For Client 1 Throughout Therapy - Five Minute Intervals

Note: Client 1 feels the emotions gradually building to greatest intensity and then back to 0 after catharsis.

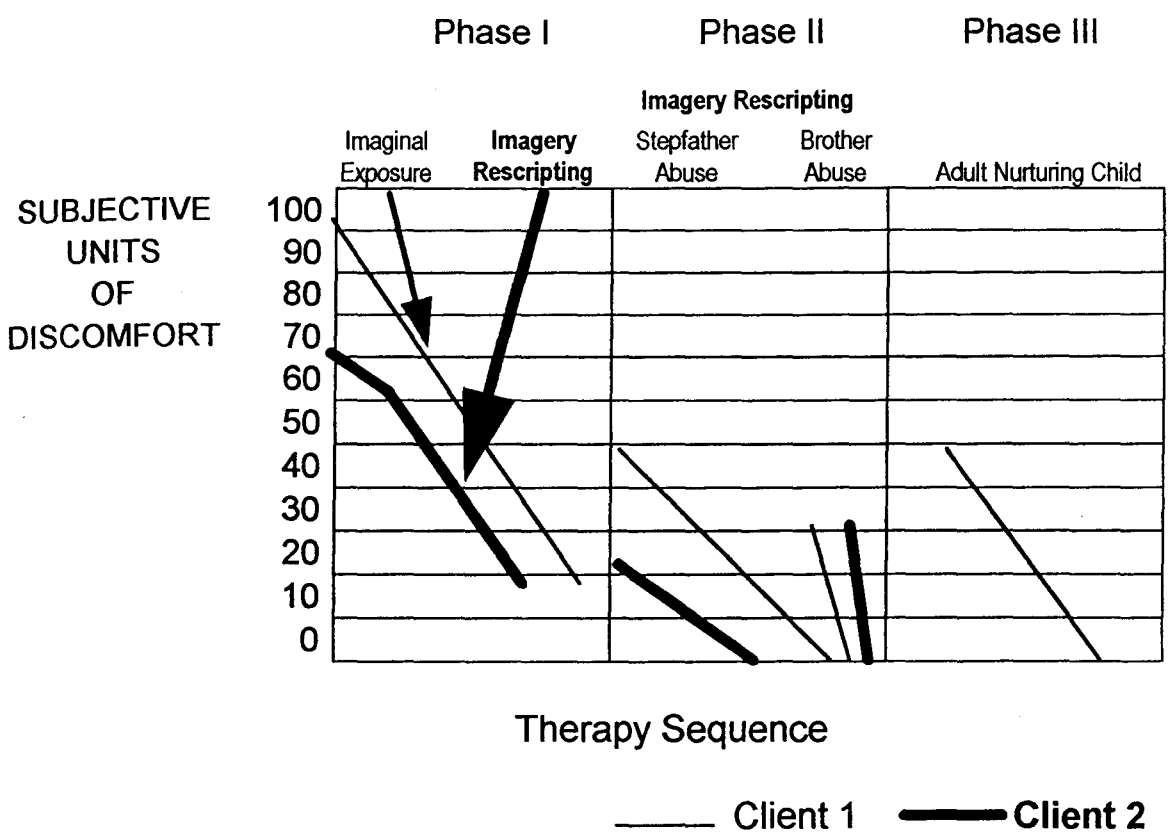

Figure 6: (SUDS) Level For client 2 Throughout Therapy - Ten Minute Intervals

Note: Client 2 only does initial processing of her brother's abuse during phase II of her therapy. More work is needed to effectively process these multiple traumas.

0 on the (SUDS) scale can indicate either numbness of feeling within the defense mechanism of **dissociation** or feeling at peace within the experience of associating affect and moving toward catharsis. Dissociation points for Client 1 and Client 2 were noted by the therapist and "worked through" until the clients were able to "stay in their bodies" and reexperience the trauma, without negative physiological arousal occurring. Thus, the client had a feeling of peace and calm, after experiencing catharsis of the particular imagery scene.

Client difficulty in Dealing with the Perpetrator

Imaginal rescripting was employed after the imaginal exposure process, to challenge and change the distressing recurring images of the PTSD response. Imaginal rescripting was employed also to effect changes in the propositions of meaning at the **schema level** (e.g., helping the client to change her helplessness / powerlessness schema by replacing **victimization imagery** with **mastery imagery**). In short, the use of imaginal exposure and rescripting allows the abuse-related schemas to be addressed through the eyes of the traumatized **child** and then, challenged, changed and reprocessed through the eyes of the empowered **adult**.

In "directing" the imaginal rescripting process it is important to notice the difficulty with which the client can confront her perpetrator(s) and or rescue the traumatized child before there can be a transformation of victimization imagery to mastery imagery.

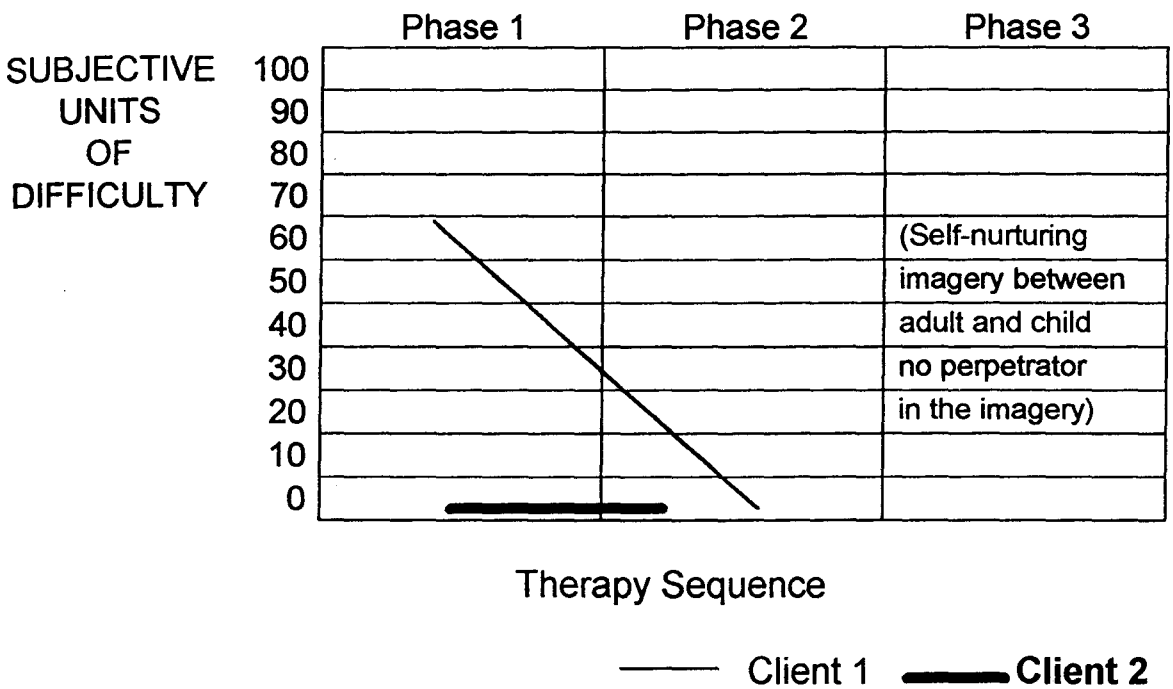

Figure 7: Comparative Client Difficulty in Dealing With Perpetrator

Client 1 had more difficulty in confronting her perpetrator in the beginning of therapy, but did improve on this. Client 2 had little diffuculty confronting her perpetrators and needed to express her rage. Thus, with the

the exposure treatment component of the session completed, the focus shifted to rescripting of the abuse scene. During exposure, the clients accessed the **visual**, **verbal**, and **affective** components of her experience, revealing traumagenic schemas such as powerlessness, self-blame and mistrust. During the rescripting phase, client traumagenic schemas were identified, clarified and challenged through imaginal action and dialogue.

In figure 7, notice that Client 2 had no difficulty confronting her perpetrators, in fact, she was moving from a very depressed suicidal young woman to an active and very physical expression of her rage. Whereas Client 1, who had great difficulty confronting people in general and her father in particular, moved with great struggle to actual confrontation of her perpetrator father in imagery. Client 1 was challenged gently by the therapist concerning unfinished business with her father. She wrote in her journal that the therapist's comment disturbed her because "I have been living a lie, trying to heal from incest and still trying to protect my father" (p. 13).

Client Capacity For Self-Calm and Self-Nurture

No graph was made of the comparative client ability to self-calm and self-nurture themselves with the use of interactive imagery between their traumatized child and empowered adult throughout therapy, because the data indicated that both clients had little or no difficulty doing this, after practicing in the initial therapy session. Sessions five through eight were intended to focus solely on self-nurturing imagery.

Client Adult-Child Imagery

As noted, in measuring the client capacity for self-calm and self-nurture after completion of the mastery imagery, the therapist fosters "adult-nurturing-child" imagery, in which the **ADULT** is encouraged to act directly with the traumatized **CHILD**. It is important, however, for the therapist to call this "Adult-Child Imagery" to the client and not "Adult-Nurturing Child" Imagery. This phase of imagery cannot be successful if the client thinks she should be nurturing the **CHILD**, and tries to force her **ADULT** prematurely to nurture the **CHILD** (e.g., anger, blame). In some cases, the client will first need to directly express such negative feelings to the **CHILD** before any nurturing feelings towards the **CHILD** can be authentically felt

and expressed. The therapist facilitates the **ADULT-CHILD** Imagery by asking questions such as:

> **What would you, the ADULT, like to do or say to the child? . . . Can you see yourself doing (or saying) that? How does the CHILD respond? How do you, the ADULT, respond to the CHILD's response?**

than for it to be directed, dictated, or suggested to them.

Many times the **ADULT** will begin to hold or hug the **CHILD**, reassure the **CHILD** that the abuse will not happen again. If, however, the **ADULT** has difficulty nurturing the **CHILD**, blames the **CHILD** for the abuse, or wants to hurt or abandon the **CHILD**, it is important for the **ADULT** to express her anger directly to the **CHILD** from close proximity. For generally, as the **ADULT** moves closer to the **CHILD**, the **ADULT** becomes more emphathetic with the child's pain and finds it more difficult to blame, abandon or hurt the **CHILD**. After it appears tht the **ADULT** has nurtured the **CHILD** sufficiently, the client may be ready to bring the imagery to a close. The therapist and client then collaboratively explore various self-calming and self-soothing strategies for the client to experiment with between sessions, especially when feeling upset.

Flashbacks Between Sessions

Finally, another PTSD symptom besides physiological reactivity is the recurring and intrusive recollections, dreams, and flashbacks by which the client reexperiences her trauma(s), because the trauma has not adequately been processed.

The original Therapist Session Form did not include specific data on the frequency of flashbacks and other intrusive memories throughout treatment, although the discourse reveals such repeated measures used by the therapist and client. Currently, the treatment manual includes an updated Therapist Record per session, a Homework Record per session, a Traumatic Flashback Incident Record for pre-treatment and each session, a Post-Imagery Questionnaire after each session and some forms for post-treatment and follow-up sessions where the theapist can record the client progress and achievement of therapy goals.

The last two graphs (See Figures 8 and 9) evidence the frequency of the traumatic memories between sessions, throughout the phases of treatment, as reported by each of the clients. What is important is not so much the numbers right now, but the change process of the quality of the traumatic memory (like being able to feel the feelings rather than numb out and/or dissociate); the client's self-confidence in coping;

the client feeling more empowered to approach, rather than avoid stimuli similar to her trauma(s) and therefore, do the needed work, in order to alleviate the PTSD symptoms, change abuse schemas and enhance the survivor's capacity for self-calming and self-nurturance.

In summary, both Clients 1 and 2 were able to really experience their original trauma(s) **visually**, **verbally**, and **emotionally** at the stage of the traumatized child during the trauma; process the usually avoidant feelings and thoughts; learn strategies to cope and deal with the recurring memories, and take courage to change their lives with more healthy adaptive patterns, than **dissociation**, **emotional numbing**, and **denial**.

Client 1

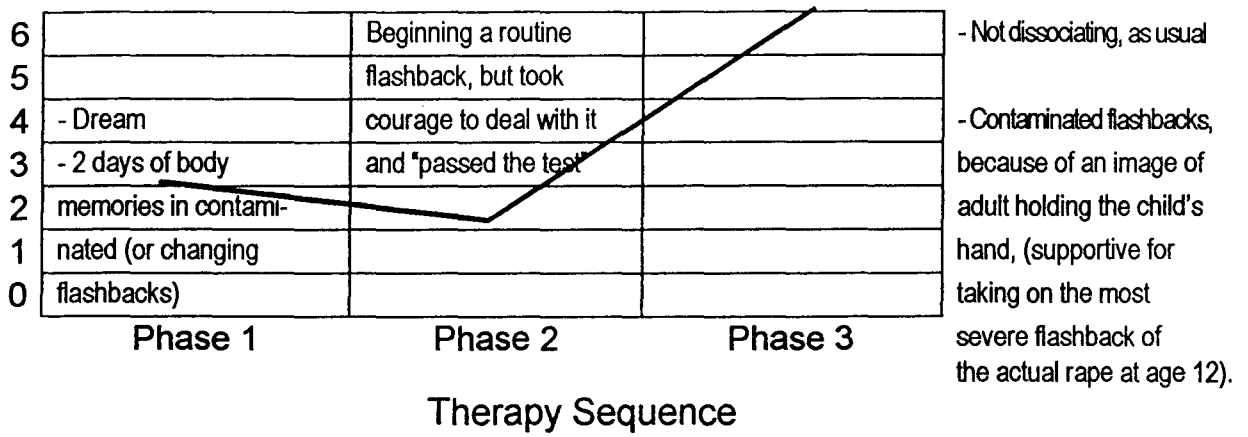

Figure 8: Number of Flashbacks Between Therapy Sessions

Client 1, in the third session of therapy representing Phase 1 of the treatment, had a dream about confronting her perpetrating father. Previously in the first session, second session, and between sessions Client 1 reported struggling with confrontation, especially with her husband and her father. This struggle very likely spilled over into her unconscious, especially during her night dreaming. In addition, as a result of her therapy work both in-session and between sessions, she was experiencing some body pain from body memories of the original trauma of physical and deeper fighting with her father and achieving her own empowerment in the rescripting phase of her imagined abuse scenes.

In the sixth session of therapy, client 1 in the middle phase of therapy reports that she did an experiment with one of her reucrring flashbacks. There was a certain stretch of curvy road (which probably reminded her of the sexual abuse experienced as a 6-year-old in a moving car driven by her out-of-control intoxicated father).

Client 1 would experience flashbacks on that road which she could not avoid on the weekly nights she went to her incest group. Clinet 1 said that this particular night she "felt so much more in control" and didn't "lose her alertness or fall into the floating feeling." (dissociation) and "stayed in charge by thinking about it and "passed the test" of coping with this recurring flashback.

In the last phase of therapy, session eight, Client 1 shared how she was changing in regard to her recurring dream of twenty-five years (her actual rape at age 12). During the homework tape of two days in a row, Client 1 was dissociating as she focused on her bedroom window in the original trauma, but then, heard herself saying, "I don't know if I could be strong enough to walk through the abuse. Then she saw her adult between herself and the window and concluded that "It's finally safe to go through this memory." Client 1 said she regained some of this memory through her other thearpy and "remembered much detail, but hadn't allowed herself to get in touch with the feelings and the pain", like now in using Imagery Rescripting. "I felt someone holding my hand, I've been

into my body. Usually I'm not in my body when I have the memory." This time I heard Dr. Smucker's voice saying, "Whatever is ahead the adult will walk through the abuse with little Dolly." . . . "I have a feeling it's going to be safe to deal with the memory now."

Client 2

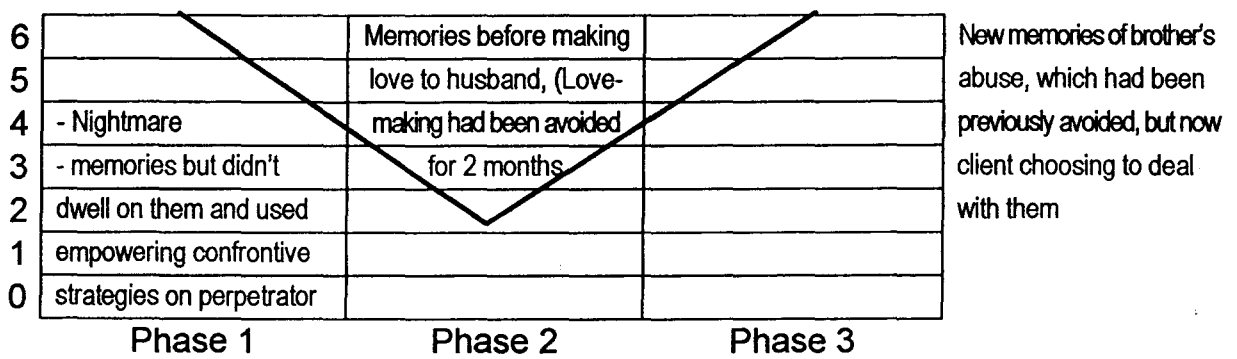

Figure 9: Number of Flashbacks Between Therapy Sessions

In phase 1 of therapy Client 2 reports that she has frequent nightmares of her multiple abusive traumas with her brothers.

However, in this third session, she states she did not dwell on the intrusive memories and used the confrontive and empowering techniques learned in Sessions 1 and 2. Basically, Client 2 was learning in the words of her therapist that "flashbacks are images which the mind creates . . . and

they were creating new images that are much more pleasant and empowering. Using these new images to replace the old ones when the flashbacks start to come . . . Bringing the adult in can help."

In phase 2 of therapy, Client 2 reports to the therapist that she made love to her husband and didn't feel guilt or shame and she felt comfortable." Right before the lovemaking, Client 2 blocked out some arising abusive memories and imagined beating up her sibling perpetrators.

In phase 3 of therapy, the standard treatment is not to do imaginal exposure or rescripting, but only self-nurturing imagery but Client 2 had multiple perpetrators and decided to deal with the abuse of the brothers in middle therapy. This decision extended her therapy beyond the average time and these new memoreis with siblings were like starting over in therapy.

This section of qualitative findings has mainly dealt with the survivors PTSD symptoms, of reexperiencing the trauma; emotional numbing; continued avoidance of similarities to the trauma and increased arousal. Now the focus is shifted to the concurrent shaping of client abuse-related schema change.

Client Abuse-Related Schema Change

The remaining goal of Imagery Rescripting treatment, in order to facilitate adequate emotional processing of the trauma, was the facilitation of cognitive change in **accommodating the meaning of the trauma** and in changing the pathogenic schemas associated with the trauma(s).

Some examples of schema changes for each client are indicated. (see Table 4.4).

Table 4.4: Comparative Client Schema Changes Throughout Imagery Rescripting Therapy

	Abuse Schemas	Schema Changes
Client 1	Powerlessness	Empowerment
(Dolly)	Mistrust	Trust
	Passivity	Assertiveness
	Abandonment	Acceptance
	Unloveability	Loveableness
	No voice	Voice
	Anxiety	Self-soothing
Client 2	Helplessness	Empowerment
(Kathy)	Self-blame	Perpetrator Responsibility
	Inherent Badness	Goodness
	Worthlessness	Value
	Self-hatred	Self-love
	Shame	Self-respect
	Depression	Assertiveness

Note: The abuse-related schemas for both clients change to more adaptive schemas.

Schema Change With Client 1 (Dolly)

The most salient theme (represented in beginning, middle and ending therapy), of abuse-related schema change to more adaptive ones, is Dolly's **powerlessness** changed to **empowerment.**

Beginning Therapy

Third Session

Some of the texts illustrating Dolly's **powerlessness** are the following:

Dolly: Confronting someone about the abuse has always been painful. I felt a physical pain in my chest (while listening to the imagery tape) the more I am urged to tell . . .
the more intense the pain is (p. 1).
I need to inform you that I am in an abusive relationship with my husband right now. My husband is a child-abuser. He physically abuses our four children (p.3) . . .
When I first go to rescue little Dolly, you ask me what I want to do and say . . . It's enough just to take her away, and **not do anything** about it and it's one of the things I've said in the tape I'm still **stuck on**.

> In the imagery, the traumatized child expresses powerlessness:
>
> I **don't have a choice**. His penis is still in my throat and I dissociate then . . . I'm choking . . . I'm going to die. (p. 16).
>
> Even to rescue the child is going to be painful and there's no eye contact wit my father in the car. He still has alot of control (p. 13).

One of the themes in the discourse contributing to Dolly's powerlessness schema was her struggle to **get a voice** in her imagery, **to speak the truth**, to expose her incestual secret to her family and especially, **confront** her perpetrator - father.

> Dolly: At this point in the imagery, I'm really angry (at my father and I swear at him "The Bastard." I've never sworn at my father in my life ever. (p. 8).
>
> This is another dream about **confronting** my Dad. (p. 9). . . . I tell my Mother, "I promised I wouldn't tell, but I don't care. Dad has been having sex with us. He sexually abused us, Mom." (p. 10). The next thing, Dad is standing

> next to her (in my dream) and his face is red from my hitting him with a spoon, and he's hanging his head (p. 11). I screamed at her everything he did to me and she began to cry harder . .. That's the end of the dream. The connections in this dream definitely connect with my being raped by my father at age 12. (p. 12)
>
> There's screaming going on and it's not my **voice**. It's in my head. Also the words I said, "Dad, you peed in my mouth." They're really in my **head**. I never really said that to you, I felt it. I wanted to say it. I couldn't speak. His penis was in my throat and I dissociate then. I never really told him that. (p. 16)

With the Adult in the imagery, the therapist asks: What would you like to do or say at this point?

Dolly: I want to tell. I want to demand that he stop the car.

Therapist: Can you see yourself doing that?

Dolly: (sigh) I can scream at him. Stop this car.

Therapist: Can you do that?

Dolly: Yes, I yelled at him to stop the car.

Therapist: Can you yell to him directly? Say it to him directly, out

loud right now.

Dolly: I don't know if I can.

Therapist: See if you can do that. That's what you want to do. See if you can pull it together to do that.

Dolly: Stop this (louder) car now! Stop it right now. You're not going to hurt us. (Breathing heavily).

Therapist: What is he doing?

Dolly: He's just looking at me. He doesn't believe I said that. I'll have to tell him again.

Therapist: Okay! Can you do that?

Dolly: **I want you to stop this car**. Stop it! Stop it right now. I'm going to grab the steering wheel. The little girl is in the way. (pp. 25 and 26).

Middle Therapy

Sixth Session

In middle therapy the homework tape which Dolly used daily between sessions had not turned out too clearly. She speculated that if the volume were there, she would have heard her voice full force and the crying and screaming which took place last session. Dolly was not able to

listen to the audiotape without breaking down. She cried along when Dolly on the tape was crying and vocalized to get her screams out. Dolly shares with her therapist in session six:

> For 35 years I felt these screams have been in my head. In the other therapy, I "talked" about the screams in my head and I've done alot of crying and breaking down but never . . . did I feel 6 years old and able to get the crying and feelings and screams out . . . You gave little Dolly or you taught me to **give her a voice** (pp 39, 40).

In becoming empowered, Dolly felt she had to imagine her father's face and little dolly's face. Confronting her father's face was especially frightening.

Unique to this client, was her conclusion that holding a conversation with her father would be powerless because realistically, there is no reasoning with him, therefore, **"her actions have all the power"** (p. 42).

> Dolly: Everyday I felt I went the full circle of emotions as I did my homework with the audiotape. I always got back to 0. I love how it feels at the end. **A feeling of power**. I could feel my adrenaline flowing when pushing Dad out of the car, in my imagery. I still cry when Dolly lets out the screams. Kind of a good feeling. (p. 42)

Ending Therapy

Eighth Session

Finally in ending therapy, Dolly shares this with her therapist:

> Dolly: This week I found myself safe to be remembering this (actual rape by her father when she was 12 years old). Now I feel it's safe to work on other memories. . I know I have other flashbacks coming, but **I know I have control** . . Now it's just like thoughts coming into my head and new little features coming to me but I wasn't devastated by it. So I think from this, I'm going to start dealing with probably the next severe thing. (p. 60)

Schema Change With client 2, (Kathy)

With Client 2 (Kathy) the most salient schema change throughout therapy was that of **self-blame** to placing the real responsibility for sexual abuse back on Kathy's four **perpetrators**.

Beginning Therapy
Third Session

In reading a letter to her stepfather which she composed in therapy, Kathy says:

Kathy: I'm not going to let the things you've done, control me anymore. You've ruined my life in many ways. I can't even have a sex life in my marriage. I'm an alcoholic. I was going crazy and I am depressed . .. I used to think **it was my fault** because I came into your room. I was **a child**. No child should have to go through this. It just feels good bringing back the blame out, where it belongs. (p. 1)

Then, in reading a letter to her younger twin brothers who also were her perpetrators, Kathy confronts her brothers and the fact that she protected them because she was afraid of getting caught. She experienced **guilt** and **shame** because she "chose" to do those things with them and accepted money and material things (p. 5).

Kathy: **I will not take the blame** and I will not feel the guilt or shame any longer, I have had enough hell with the sexual abuse.

. . . I learned right now from you .. (therapist) to stop blaming myself.

He (perpetrator) ejaculates into the bed and he says, "Look what you've done to me." **I feel guilty**. I'm a bad person.

In the imagery work with the adult / child interaction, Kathy says:

Kathy: . . I know it's not her (child)'s fault. I wish I could do more so it hadn't happened . . . She's not responsible.

Therapist: Can you say that to her?

Kathy: "**Kathy, you're not responsible** for what happened to you **it's not your fault**."

Therapist: How does she respond?

Kathy: I know I tried to get away. **Help me**."

Middle Therapy

Sixth Session

During middle therapy, major schema changes are noted in the dialogue.

Kathy tells the therapist one of her major breakthroughs since Imagery Rescripting began:

Kathy: **I made love with my husband. I didn't feel no guilt or shame.** I felt okay making love. I have a hard time stating my needs and wants . . .

Therapist: This is the first time you've made love with Randy for how long?

Kathy: 4 months.

Therapist: Were you able to climax?

Kathy. Yes.

Ending Therapy
Eighth Session

Finally, in ending therapy during the adult / child interaction imagery, Kathy discovered her "happy little girl" (Kept from her by her guilt over the abuse) and her adult as a "strong and caring person."

Kathy was seeking "a new life," receptive and responsive in exploring **her world** together with her child and strong adult.

The therapist summarizes Kathy's learning's and experience in therapy especially in ending therapy by the following response:

Therapist: So you and little Kathy will continue to explore your world together enjoying it together with her and perhaps guiding her along the way.

Kathy: **I'd like to please little Kathy and myself, instead of everyone else.**

Summary

It is proposed that Imagery Rescripting as indicated through the evidenced qualitative analysis of therapeutic discourse, facilitates adaptive processing of childhood traumas by reducing intrusive PTSD symptoms and changing abuse-related beliefs and schemas. Therefore, **Research Question One** and **Hypothesis 1** has been supported. Based on this positive relationship between Imagery Rescripting therapy and effective emotional processing of traumatic incest, **Question Two** follows:

If there is a positive relationship between Imagery Rescripting and adequate emotional processing of traumatic incest, what are the major specific treatment interventions?

It was predicted that Imagery Rescripting contains two specific treatment interventions which adequately process traumatic incest over a short period of time.

Hypothesis 2: Imagery Rescripting therapy contains two specific treatment interventions which adequately process traumatic incest over a short period of time.

Hypothesis 2 was supported from the evidence of the literature as well as, the qualitative findings as given previously.

In the words of the originator of Imagery Rescripting, "Imaginal exposure is initially used to access the traumatic memory "network" and re-experience the original trauma with its associated affect. Imaginal rescripting is then employed (1) To challenge and modify the distressing recurring images of the PTSD response, and (2) To effect changes in the meaning propositions at the schema level (Smucker et al, 1995). These processes are addressed through the adult / child imagery by which the **abuse-related schemas** are **challenged and changed** as experienced by the traumatized child. These abuse-related schemas are finally **reprocessed** through the empowered adult. (see Table 4.4 for a listing of the specific interventions, intended result therapist role and client change and also refer to table 4.5 for

client dialogue connected with each major treatment intervention of Imagery Rescripting).

Table 4.5 Imagery Rescripting - Major Interventions and Client Change

Intervention	Intended Result	Therapist Role	Client Change
Imaginal Exposure Using Adult / Child Imagery	Access trauma memory - Image - Affect - Thinking Re-experience feelings and thoughts at time of trauma.	Facilitator/ Socratic questioner/ safe presence for client "working through" trauma Empathic Supporter Director	Catharsis of trauma Dealing with **Dissociation, Denial** and **Emotional numbing** Alleviation of PTSD symptoms
Imaginal Rescripting Using Adult / Child Imagery	Changing Victimization Imagery to Mastery Imagery Traumagenic Schemas further identified and challenged	Supportive Challenger Delicate Confronter Non-directive Facilitator Socratic qeustioner Enhancer of Survivor's capacity to self-nurture and self-calm	Powerlessness changed to empowerment Other abuse schemas emerging Alleviation of PTSD symptoms Integration of trauma meaning in survivor's life Cognitive re-processing of abuse schemas and change to positive schemas

In synthesizing the qualitative findings in response to Hypothesis regarding the positive relationship between Imagery Rescripting and the effective emotional processing of the survivors' traumatic incest the following conclusions are drawn:

1. Through the intervention of imaginal exposure of Imagery Rescripting the survivors were able to access the original traumatic memory and reexperience it within their uniqueness.
2. Through the intervention of imaginal rescripting the survivors were able to exchange mastery imagery for victimization imagery.
3. Through Imagery Rescripting's two major interventions as noted and 1 and 2 (response to hypothesis 2), abuse-related schemas were changed to more adaptive schemas.
4. Throught the use of adult/child imagery, the survivors grew in their self-nurturing capacity.

The final two hypotheses regarding the therapist structure linking Imagery Rescripting's theoretical assumptions and the model's intended sequence, as well as examining the client and sequence similarieties along with the differences for studying the therapist participation will conclude the section on qualitative findings.

Therapist Structure and Imagery Rescripting's Theoretical Assumptions

Research Question Four reads: How does the resultant (therapist factor) structure link therapist participation and Imagery Rescripting's theoretical assumptions and Intended sequence?

It was predicted that the resultant therapist factor structure would link the therapist participation and Imagery Rescripting's theoretical assumptions and intended sequence.

From the study question four, the following hypothesis was derived to examine the derived therapist participation structure as a link to Imagery Rescripting's theoretical assumptions and intended sequence. Hypothesis 4 states that this resultant structure will link the therapist participation and Imagery Rescripting's theoretical assumptions and intended sequence.

Hypothesis 4 was supported as measured by the current treatment manual (Smucker et al, 1996) of Imagery Rescripting and the evidence concerning the therapist participation factor structure (as noted earlier in this Chapter).

Table 4.6: Client Dialogue During the Major Interventions of Imagery Rescripting

Treatment Intervention	Client 1	Client 2
Imaginal Exposure using Adult/Child Imagery	When I dissociate I'm up in the car windshield looking at the scene. I don't have a choice. His penis is in my throat . . . I have to breathe . . . I want to throw up.	He leaves . . . I feel bad what we've done. I still feel scared. I just feel so dirty and I'm being used over and over . . . and finally he's done.
Imaginal Rescripting using Adult/Child Imagery	I wish I could be driving the car. That would take the power away from him and the "little girl" is next to me on the seat. My child and I are relaxing together outside where we feel safe . . . this is what normal childhood is.	I grab him by the neck. I tell little Kathy to go to the living room and I hit him a dozen times with a baseball bat. It feels good to see little Kathy happy . . . and it feels good to protect her . . . They can't harm her now.

Linking the Therapist Participation Structure With the Theoretical Assumptions of Imagery Rescripting

Using the first twelve rank ordered therapist variables on the (SICS) instrument listed for each client in Table 4.2, an analysis was made of the relationship between the factor structure and the theoretical assumptions of Imagery Rescripting.

For both Client 1 and Client 2, the highest therapist variable is **"person of the client."** Therefore, Imagery Rescripting evidences a client-centered philosophy. The next therapist variable appearing on the coding sheet 168 times for both clients is **informing** and it captures the therapist activity of providing or attempting to obtain **needed client information**, so as to "direct" the Imagery Rescripting treatment and/or individualize the treatment according to this specific model. According to this investigation, the information which is affirmed, is mainly what pertained to Imagery Rescripting and its implementation. For example, Client 2's sharing of her marital concerns, regarding the counseling with her minister, is not affirmed by the therapist, who moves on to the focused treatment.

The next highest therapist variable for Client 1 is **answering**, which pertains to the therapist answering a client question or a directive. Client 1

is a critical thinker and consistently brings questions to the therapist concerning Imagery Rescripting treatment. For example, this is one of Dolly's questions in session three, "When I gain more power and control in my flashbacks and dreams will I gain more control in my present life?" The therapist responded in this way:

> This is an **empowering experience** for you. I think you're going to find as a result of this, you will not start to have your anger spilling out and you starting to physically attack people. What might happen is that you will be less tolerant of abuse that occurs to you or to your children and you will confront it more openly and directly.

Client 2 does not bring alot of questions concerning the therapy. The next highest therapist variable for her is **directing** which means the therapist makes explicit demands of the Client, like, "Let's get into the imagery."

Client 2, as compared to Client 1, seems to need more direction in general from the therapist, like how to do her homework.

Instead of analyzing each of the remaining rank-ordered therapist variables, for each Client; as a link to theoretical assumptions of IRT, a

grouping of the remaining variables will be done for each Client and then, related back to the theoretical assumptions of the model.

For Client 1, the therapist categories of **minimal verbal regulation and contentless words** meant that the therapist involvement was minimal because Dolly was able to take initiative in "working through the therapy," but also, where Dolly was stuck or dissociating, the therapist was patient and supportive in allowing the Client to take the lead in the imagery. Thus, the therapist participation was intended to be as non-directive as possible.

Also with Client 2, to the therapist category of **minimal verbal regulation**, was added **affirmation, positive evaluation, and positive affect and lacking temporal orientation,** because Kathy was younger and less mature, less verbal and needed more reassurance from her therapist in pursuing the imagery work.

The therapist participation with both Clients in general was empathic, facilitative where appropriate and individualizing according to Client need within the model.

Relationships - with **significant others** and the **therapist** seemed to be a high priority for Client 1. Imagery Rescripting theoretically is not highly relational. The therapist did not verbally affirm Dolly's relation-

ships, unless the relationships pertained to Imagery Rescripting. Even though this treatment is mainly individual, and can be used as a first abuse-focused therapy, an adjunct or a break through therapy with this population, could not the therapist reaffirm Dolly's relational world? In spite of this lack, the therapeutic bond did appear to be trusting, safe, and strong.

The therapist used the skills of **confronting, and comprehending** in helping Client 2, Kathy to deal with the **distant past** of her brother perpetrators, which was a more disgusting experience for her than the incest by her stepfather. She needed more challenge and help in processing and integrating the meaning of her trauma with her siblings into her current life. She was not as questioning and reflective and benefiting from the life cycle as Dolly who was, at least ten years older than Kathy. Finally the **work / leisure** category was expressed with Kathy more than Dolly, since Kathy and her husband had no children; Kathy was attending school and seemed to socialize more with her husband.

Finally, the therapist participation with Dolly included **directing**, and **initiating**, and **dealing with the distant past**, especially when Dolly was frozen with fear and/or confused as the traumatized child and struggling adult. The therapist could frequently communicate **cognitive appraisal**

because Dolly was inquiring and a critical thinker. Cognitive appraisal came naturally for Dr. Smucker, a cognitive therapist.

Therapist Participation and Intended Model Sequence

In responding to the final portion of Hypothesis 4 regarding the intended sequence of the model, Dr. Smucker writes in his current manual (1996) that the two interventions - **imaginal exposure and rescripting** are used concurrently in sessions one through five, then the first two interventions are not used after session five, unless the "adult" remains unable to confront the perpetrator directly and rescue the "child" from the abuse(s). Usually, the imagery focus in sessions six through ten, is that of adult / child interaction imagery. In 1992, when these clients were videotaped, sessions six through eight were intended to focus on adult / child imagery. However, both Client 1 and Client 2 in this study, did not begin the shift until session seven. This likely was the case because Client 1, Dolly, really struggled with confrontation of her perpetrator father and Client 2, Kathy, had multiple family perpetrators. Kathy had done most of her abuse work concerning her stepfather, and initially had been reluctant to pursue work on the traumatic abuse memories by her brothers.

The study demonstrates that the therapist had the intended sequence of Imagery Rescripting in mind, but deviated from the standard treatment, so as to adjust to Client need and individuality. So for both Clients, the shift to full focusing on the adult / child interaction did not come until session seven, a session later than the standard. See Table 4.7 for a summation on Imagery Recripting's major interventions, theoretical assumptions and intended sequence.

From the intended sequence of the Imagery Rescripting Model, one can see why the therapist structure is not consistent across phases of therapy because the essence of the beginning phase of therapy and the ending are different, and the essence of the beginning and middle phases of therapy are different. These phases of therapy are initiated by the therapist according to the readiness and pacing of the individual Client.

Table 4.7: Main Theoretical Assumptions and Intended Sequence of Imagery Rescripting's Major Interventions with Women Survivors of PTSD-Related Incest

Specific Population	Specific Problems	Specific Imagery Rescripting Treatment Interventions	Theory	Intended Sequence
Women survivors with incest-related PTSD.	Concurrent presence of PTSD symptoms and abuse-related schemas in childhood sexual abuse survivors.	<u>Treatment Interventions</u> - Imaginal exposure, Imaginal Rescripting using adult/child imagery - simultaneously address the intrusive PTSD symptoms and the underlying abuse-related beliefs and schemas. <u>Treatment Goals</u> 1) Decrease physiological arousal 2) Eliminate intrusive PTSD symptoms 3) Replace victimization imagery with mastery imagery. 4) Change abuse-related cognitions and traumagenic schemas 5) Enhance capacity to self-soothe and nurture.	Expanded information processing model of PTSD. Schema Theory Traumatic memory research Abuse-focused therapy for adult sexually abused as children.	In 1992, with these clients the interventions of exposure and rescripting were not done in sessions seven and eight. (1992 update, these two interventions are not to be used after session five, unless the adult cannot visualize herself as an empowered adult confronting the perpetrator and rescuing the child from abuse without difficulty.)

Client Similarities and Differences With the Therapist Participation

Finally, in answering Research Question Five:

While being consistent with the Imagery Rescripting model, how does the therapist participation adapt to Client differences and sequence differences across phases of therapy?

The following hypothesis was derived:

Hypothesis 5: Adhering to the treatment model, therapist participation will demonstrate Client and sequence similarities, as well as differences.

It was predicted that the therapist participation while adhering to the model of Imagery Rescripting as measured by the current treatment manual (1996) will demonstrate both client and sequence similarities and Client and sequence differenece. Many of the similarities and differences for each client have already been presented and elaborated upon, for further synthesis and details, (See Tables 4.7 and 4.8).

Table 4.8: Therapist Participation, Client Similarities and Differences Within Imagery Rescripting Therapy

Therapist Participation	Client Similarities	Client Differences	
		Dolly	Kathy
Pre-treatment evaluation and assessment	Severe incest PTSD diagnosis Willingness to learn and do Imagery Rescripting Ability to do the therapy	Forced sexual abuse by alcoholic, threatening father	Multiple perpetrators
Treatment Goals 1) Decrease physiological arousal 2) Eliminal PTSD Symptoms 3) Replace vicimization imagery with mastery 4) Change abuse-schemas 5) Enhance self-soothing	Completed treatment Learned new strategies for coping and eliminating PTSD symptoms No diagnosis of PTSD at end of 3 sessions Victimization changed to mastery Other schema changes	Middle-aged 4 children Incest group Couples Therapy Protective Services Not-alcoholic	Young adult 0 children Hospitalization for depression Treatment for alcoholism
Treatment Process Established an effective therapeutic relationship Conducted abuse-focused therapy effectively Adhered to Imagery Rescripting Model Adapted in general, to client differences Affirmed client progress in TX Model	Did homework between sessions Did re-experiencing of trauma, rescripting and nurturing imagery; were motivated for continued recovery from incest. Accomplished a healing therapeutic bond with therapist Achieved successful abuse-treatment focused goals	More self-actualizing More critical about the treatment More detailed in "telling her abuse story" More difficulty confronting perpetrator Fear of being violent	More dependent on therapist More trusting on the therapist's expertise More general in "telling her abuse story" More satisfaction in violently attacking perpetrators

Table 4.9: Therapist Participation, Sequence Similarities and Differences Within Imagery Rescripting Therapy

Therapist Participation	Sequence Similarities	Sequence Differences	
		Dolly	Kathy
Therapist conducted sessions one through five on standard protocol of Imagery Rescripting (ie., concurrent two interventions and adult/child imagery).	Clients began treatment with targeted abuse memory by mutual agreement with therapist.	Wanted to change abuse memory chosen, in order to concentrate on the actual rape scene at age 12.	Kathy had processed the chosen targeted abuse by her grandfather, but brought up abuse by her brothers.
Therapist listened to the client, but presented the challenge for the clients and allowed the clients to make their decision in light of his suggestions.	Both clients, through the therapist persuasion and "direction," stayed with the needed targeted abuse memory and therefore, needed a session more than standard protocol to process their abuse memory adequately.	Therapist kept with the first targeted abuse memory, but offered to deal with the rape memory next.	She was avoidant with the latter, but the therapist presented rationale for doing it and left the decision to Kathy. (She ultimately chose to deal with the sibling abuse, although it was difficult).

Summary

The therapist's interactive participation as measured in this study, does essentially link with the major theoretical assumptions underlying the major interventions of **Imaginal Exposure, Imaginal Rescripting**, and the use of **Adult/child Nurturing Imagery** within the Imagery Rescripting model and its intended sequence. The (SICS) instrument factored out the dominant therapist variables which connect with the specific goals of (IR). For example, in the use of Imaginal Exposure the client accessed her original trauma and reexperienced the feelings, thoughts and schemas stored within her traumatic memories.The therapist attempted to sensitively facilitate and empower the client within her unique style and meaning, through the beginning phase of therapy. He informed and educated the client about the use of (IR) as she moved from the exposure phase of treatment to the rescripting phase of treatment, moving into more change within the middle phase of therapy where the interventions are used to greater depth. The adult/child imagery used throughout therapy (especially in full force in the final phase of therapy) eased the client's fearful journey through victimization imagery which confronted her perpetrator(s) and rescued her traumatized child. She then became empowered in the mastery imagery phase or rescripting by a healing catharsis, cognitive

reprocessing of her abuse and re-integration of her disconnected physical, emotional, cognitive and social elements of her experience. The last phase of therapy, encompassed the beginnings of re-integration of the client's trauma and the more adaptive movement toward the future, rather than being stuck in abuse-related schemas and behaviors such as shame; guilt; dissociation; denial; and avoidance.

Summary of Qualitative Findings

The Client data from a repeated measures scale collected by the therapist both on the therapist form and within the transcribed therapeutic discourse suggested that a positive relationship exists between Imagery Rescripting and effective emotional processing of traumatic incest by women survivors. Both Clients reported a reduction in PTSD symptoms, a change in abuse-related schemas to more healthy ones and an enhanced capacity to self-soothe and self-nurture in their continuing recovery from traumatic incest.

They cited the benefit of the two major treatment interventions of **Imaginal exposure** and **Imaginal rescripting** with **the adult / child interaction imagery,** as well as the therapist relationship, in accomplishing their therapy success.

The therapist's verbal responses within the treatment process were actually categorized from many perspectives on a standardized instrument, which then was statistically measured to discover its **basic general structure** consistent with both Clients and differing across three phases of therapy. This structure named **"Directing insightful / painful therapeutic work"** does capture the nature of Imagery Rescripting's treatment interventions within an empathic therapeutic context of abuse-focused therapy. This structure of the therapist participation differed across phases of therapy because the phases of therapy are planned to have a major shift between beginning and ending therapy and beginning and middle therapy.

For example, beginning therapy emphasizes the use of the two major interventions of Imaginal Exposure and Imaginal Rescripting with the use of Adult/child Nurturing Imagery whereas the final phase of therapy solely uses Adult/child Nurturing Imagery. Middle therapy in this model implies the use of the interventions to greater depth with the possibility for greater change than in the beginning phase of therapy.

With a current treatment manual as a measuring tool, the resultant therapist participation structure did connect or **link Imagery Rescripting theoretical assumptions** and **intended therapy sequence**.

Finally, client and sequence similarities were noted after the therapist's treatment with Imagery Rescripting. Likewise, Client differences and sequence differences were noted because theoretically and actually the therapist's participation was Client-centered and adapted to Client cues for individualization. However, further specificity in client diagnosis and treatment matching could effect a greater client-centered model.

CHAPTER V

DISCUSSION AND IMPLICATIONS OF THE FINDINGS

The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based on empowerment and the creation of new connections. Recovery can take place only within the context of relationships, it cannot occur in isolation.

– *(Herman, 1992, p. 133).*

INTRODUCTION

It is important to think about the findings reported in Chapter IV, so as to obtain a clear understanding of what these quantitative and qualitative results mean for social work. What do the findings tell us about Imagery Rescripting therapy and women who are survivors of PTSD-related incest; therapist verbal interactive participation; and client change within a victimizing culture and socioeconomicpolitical age of health care reform? What do the findings tell us about the specific research methodology used? What do these findings suggest about the value and use of process research for social work research?

The findings of this study have significant and varied implications for social work practice and social work research. This relationship will be

elaborated upon in greater detail in this Chapter, since the strong relationship between research processes and clinical findings is used as a basis for discussing important implications for social work practitioners.

Practice Implications

This study was successful in elaborating on three relationships: 1) the relationship between Imagery Rescripting therapy and the therapist verbal interactive participation structure; 2) the relationship between Imagery Rescripting and the population of women survivors of PTSD-related incest; and 3) the relationship of Imagery Rescripting and unique client change in Dolly and Kathy who engaged in the therapeutic context of Imagery Rescripting, within the wider cultural context. Two different techniques were employed in this study. The first technique - one with a purposeful focus on quantifying the data and analyzing it statistically - used a standardized instrument for each therapist verbal participation category with each participant throughout selected beginning, middle, and ending treatment sessions. From a traditional research perspective, these statistical relationships might have appeared to be important enough, to base social work practice-related generalizations on. However, as discussed in detail in Chapter III, this study also used qualitative methods via discourse analysis of videotaped therapeutic interviews. In using

Imagery Rescripting rather than reduce the concepts of therapist verbal participation and client change to scores alone, an effort was made to broaden the study and to incorporate other features assumed to be of relevance for clinical social work practice. For example, an examination of the personal and social contexts of the incest survivors and their affective, cognitive and behavioral referents were explored in this research . Some research methods concentrate solely on symptom-based criteria (to be checked off in a diagnostic and statistical manual), the current study examined client feelings, cognitions, schemas and actions in relation to her whole person within her complex environment. The therapist's verbal interaction with the therapeutic context also was examined and compared across two clients and three phases of therapy. This blend of methods - employing scales, measures and therapeutic discourse analysis is central to the understanding of findings in the current effort.

Imagery Rescripting and PTSD-Related Incest

This study has significant implications and applications for social work practitioners and other mental health professionals who provide services to individuals who have survived incest and are diagnosed with post-traumatic stress disorder (PTSD).

Social Considerations.

As discussed in the introduction, Donaldson and Gardner (1985) and Lindberg and Distad (1985) documented that there was a 96 to 100% prevalence of PTSD in the population of survivors of sexual abuse and that the incidence and prevalence of **incest** indicates that it is a growing social problem (Russell, 1986; Draijer, 1988).

The history of social work demonstrates concern for social issues and the advocacy for those who are victimized and "disadvantaged." The participants in this study (Chapter III) describe their incest experience as violent, degrading, and damaging within their own families which reflect the cultural victimization and violence. Kirschner et al (1993) presented the "incest survivor syndrome," so as to understand the women survivors and appreciate their short and long-term effects of traumatic incest. Briere (1989) also highlighted the victimizing culture's impact on both the survivor and the professionals who serve this population.

The nature, origin, and historical development of **post-traumatic stress** was discussed in Chapter II, as a help in understanding part of the presenting problem within the survivor population. Numerous approaches to PTSD were elaborated on in the literature review - **psychoanalytic schools**; **cognitive theories**; and **biological** and **behavioral** models culminating in the evolution, description and rationale for **Imagery**

Rescripting therapy (Smucker et al, 1995 and 1996) chosen for this exploration and evaluative inquiry.

This research attempted to explore and evaluate the proposal that Imagery Rescripting "effectively processes" the traumatic incest of women survivors and attempted to examine its major interventions and the resultant client change, by analyzing the therapeutic process in the words of both the therapist and the client.

A social point of view, supported by the women in this research, considers a sense of basic human connection to be the product of ongoing, "normal" development. The current research on infant development as cited by Czogalik (1994) challenges the psychoanalytic assumption of maturational growth stemming from symbiosis to autonomy. Stern (1985) has proposed that infants are born social, coming into the world equipped for social interaction. From this perspective, the goal of infant behavior is to become securely attached to the parent or caregiver. This is important for women clients and their therapists. An attachment was in fact demonstrated by the women as they discussed their gains in therapy. **Connectedness**, from this viewpoint, is not "the result of failure in differentiation . . . but a success of psychic functioning" (Stern, 1985, p. 24). Relational theory suggests that adults as well as children have this basic, biosocial motivation to make secure, close connections with others.

The nature and quality of the participants' attachments were important and their willingness to change themselves to establish, maintain and in some instances, change emotional ties to family was evidenced in therapeutic dialogue. From a social perspective, incest is usually a chronic trauma rising out of disrupted and disconnected family relations within a disconnected and violent society.

Economic-Political Considerations.

As alluded to in the introduction and throughout the study, the health care environment in the United States is rapidly changing, both **economically** and **politically**. There have been and continue to be changes in funding. In the united States social workers in direct practice in health care must respond to the defeat of President Clinton's national health care plan and to the Republican takeover of Congress, both of which are expected to decrease federal spending on **health care**. Greater fiscal responsibility is shifted to states and communities for the provision of health, welfare and other human services. This shift comes at a time when the health status of poor and ethnic minority populations is significantly behind the rest of the nation. Perhaps more than before, social workers in health care must perform their array of direct practice functions, including **advocacy**, **community planning**, **resource development**, **policy**

development, and **legislative reform** and still more work will likely be needed to protect and secure health care and other entitlements of chronically ill people.

Violence prevention such as in the cases of incest, is a national priority as well. Violence is expensive. It affects services in emergency rooms, hospitals, doctor's offices, social worker's office's. It causes lifelong effects and disabilities (as noted throughout this study) that society usually must pay for in the way of rehabilitation, long-term care, and other assistance. Job opportunities for health care social workers in violence prevention should increase.

Primary care in the United States, however, tends to be physician driven and "big business insurance companies" driven. It reflects a predominately medical model of care, rather than a social work life model. The current health care system is tending to provide acute, episodic and first-encounter care only. As such, they operate as primary health care centers in name only, because they provide few, if any, opportunities for psychosocial interventions with Clients and families (as social workers do).

Finally cost containment measures in the delivery of mental health care should affect social workers as well. Health care costs have risen dramatically over the past decade, accounting for 40% of all employer health care costs. Third-party payers have recently implemented managed

care and capitated payments to contain these costs. This system will likely provide more job opportunities for social workers, simply because social work services tend to be less expensive than other services provided by psychiatrists. Therefore, this study seeking an efficient but cost-effective treatment for traumatic incest is significant for social workers and other mental health professionals practicing in the rapidly changing socialeconomicpolitical environment of health care in the United States, (Poole, 1995).

Imagery Rescripting and Therapeutic Context.

A major emphasis throughout the study has been that of the therapeutic relationship (which was first highlighted in chapter I), because of its relevance for clinical social workers and their historical commitment to enhancing the **therapeutic relationship** (Garrett, 1949; Hollis, 1964; and Perlman, 1979), as well as developing interventions which help the client problems and situation. The entire quantitative section of this study was devoted to discovering and analyzing the **therapist participation structure** in the use of Imagery Rescriptng therapy. While adhering closely to the treatment model, as measured by a current treatment manual, the structure of the therapist participation demonstrated specific change results corresponding to two major specific treatment interventions with the targeted population (which will be elaborated upon in the next

section). The therapist structure was named **"Directing insightful / painful therapeutic work"** (Czogalik and Russell 1995) which is the essence of Imagery Rescripting treatment with survivors of PTSD-related incest (Smucker et al, 1995 and 1996). The study, according to the findings in Chapter III, evidenced client and sequence similarities throughout therapy, as well as client and sequence differences, with the therapist participation adaptation throughout the course of therapy. The findings also demonstrated that there was a link or a direct connection to the theoretical assumptions of Imagery Rescripting and its intended sequence and how the therapist participated verbally in the therapy process with unique and individual clients.

Specifically, Imagery Rescripting was considered to have "effectively processed" the traumatic PTSD-related incest of the two participants by concurrently targeting the reduction of PTSD symptoms as described earlier and to have modified the abuse-related schemas (described in Chapter II and Chapter III) with the two major interventions of **Imaginal Exposure** and **Imaginal Rescripting**, using adult / child interactive imagery.

As discussed in the literature review, Briere (1989) asserted that even more important than knowledge of abuse effects and treatment techniques is the therapist's general orientation toward working with sexual

victimization. As disciphered from the therapeutic text, the therapist was **empathic**, **affirming** and **client-centered** most of the time; more with the treatment application, than with the client's relational situation. Briere proposed that survivor-oriented therapy specifically focuses on the original abuse context, as one of the key issues in treatment, relating this early trauma to later and current experiences and behavior of the clients. Essentially, Dr. Smucker did demonstrate this philosophy in his use of Imagery Rescripting therapy. From therapist interactive participation analysis, Dr. Smuckers did evidence Imagery Rescripting as a **growth model**, rather than a medical model, within the abuse-focused emphasis of post-trauma sexual abuse. However even though he approached the survivor as "not inherently sick," he could have stressed specifically, that the client appropriately accommodated to a toxic environment of violence and victimization. According to Briere, these accommodations to the abuse (e.g., dissociation) were "healthy" at the time of the abuse, and therefore, the client's current predicament is one of updating her survival behaviors and perceptions than being cured of an illness. Dr. Smucker could have emphasized the "victimizing culture" and thereby, **normalizing** (using an educational component) the client's response to incest trauma in the violent culture of the United States. The therapist did stress the adaptive basis of postabuse difficulties by empowerment of the client in the **mastery**

imagery; facilitating abuse-related **schema change**; and effecting an enhanced capacity for **self-comfort** and **self-nurturing**. Therefore, Imagery Rescripting abuse-centered therapy, is less interested in client weaknesses and more focused on client strengths.

Undoubtedly, as recognized in the section on transference and countertransference by Briere in Chapter II, the quality of the therapeutic relationship per se is even more crucial than the specific abuse-focused treatment interventions. As with other types of relationships, both therapist and client are vulnerable to biases in perception and expectation as they move to define and understand each other, and **create meaning together** (Saari, 1991) in the therapeutic context of Imagery Rescripting therapy.

The therapeutic relationship in abuse-specific treatment may be especially difficult with survivors because abuse-specific treatment directly accesses childhood trauma and so increases the survivor's responses of **rage** and **sexualization** with the therapist as "authority figure" and "significant person." The therapeutic dialogue did not evidence client verbal assaults toward the therapist or the therapist evoking of client rage or sexualization toward him. There was one example with Client 1 and the therapist where Dolly appeared irritable with him when he was not attuned and tracking with her and he had verbalized a response to her following his

own idea, rather than listening to her. He caught this and responded to her appropriately.

As defined in Chapter I, **dissociation** is the cognitive separation of an individual from her environment at times of stress (Briere, 1989). The therapeutic context paradoxically from the survivor's perspective has commonalties with her abuse experience - relationship with an authority figure, likely to be male and both experiences are emotionally painful, demanding **vulnerability**. Therefore, the client may **dissociate** during therapy, as she did during the abuse trauma(s). The therapist using Imagery Rescripting therapy was patient during the occurrence of dissociation with both clients and gently was able to challenge and facilitate change in the client's behavior.

Finally, even though Dr. Smucker did not provide an educational component regarding a victimizing culture or a **feminist perspective of social work**, he was aware of and sensitive toward client-gender issues, such as his own maleness in the therapeutic alliance. He moved with the client needs and individuality, throughout the therapy on client-gender issues. For example, Kathy in her chronic depression needed to externalize her rage toward multiple family perpetrators, escalating to a very aggressive, violent imagined attack of her abusers. The therapist facilitated and sensitively maneuvered her through expression of this rage, rather than

the socialized expectation of Kathy being a nurturant, passive, and easily victimized woman.

Imagery Rescripting and Client Change.

As was indicated in the literature review on the results of Imagery Rescripting in the clinical outcome pilot study, no client (the two participants in this study were included in that 1992 study) at the end of treatment, had a diagnosis of PTSD. In addition, they exhibited a reduction in PTSD symptoms and positive changes from abuse-related schemas to more adaptive ones (See the findings in chapter III).

As indicated and discussed throughout this study, the participants in this study moved toward "effective processing" of their incest trauma(s), through the use of Imagery Rescripting's theory-based assumptions of concurrently targeting the PTSD symptoms and distorted abuse cognitions, using self-nurturing imagery, Imagery Exposure and Imagery Rescripting.

For both Dolly and Kathy, there were change commonalties, yet unique variations and sometimes individual differences. They both experienced severe, chronic incest within their families - one, forced and threatening sexual abuse and rape with her father and the other, "chosen" sex experiences with step-father and three brothers. Both had a pre-treatment PTSD diagnosis and at post-treatment, did not possess criteria

for such a PTSD diagnosis. Both experienced a reduction in PTSD symptoms, especially a decrease in their levels of distress from post-trauma effects and great change in the quality of their traumatic memories. Both Dolly and Kathy were able to approach and deal with their trauma(s), including change from **dissociation**, emotional numbing, denial and avoidance. They both became adept at soothing themselves and integrating more self-nurturance in their current life and their continuing recovery into a hopeful future.

Regarding some of the **schema change**, Dolly moved from "not having a voice to getting a voice," and Kathy moved from chronic depression (rage turned inward) to aggressively expressing her rage toward her perpetrators in imagery. Dolly moved from avoidance of confrontation of her perpetrator to appropriate and unique confrontation of her father; whereas, Kathy moved from depressed passivity to satisfaction in imagined, violent attack of her multiple abusers. Both clients moved from the schema of powerlessness / helplessness to empowerment and pursued continuation of their interrupted self-development. Both Dolly and Kathy learned that never does the child have responsibility for the incest, but the adolescent or adult perpetrator is responsible for such victimization and family betrayal. Kathy was able to find effective ways of dealing with her marital sexual dysfunction and Dolly was able to take courage and confront

and change current spousal abuse and child physical abuse by her husband.

Both clients were able to understand the essentials and rationale for Imagery Rescripting therapy and the importance of doing the required homework and application of their new learning's between sessions. They were reinforced by the therapist in these new learnings and strategies of Imagery Rescripting for dealing with their specific problems and were motivated to complete the treatment program and continue the techniques throughout their post-abuse recovery.

In summary, the client data from a repeated measures design using therapist-collected data, and analysis of therapeutic dialogue evidenced that **there is a positive relationship between Imagery Rescripting and "effective emotional processing"** of traumatic incest, by means of two major specific treatment interventions within the therapeutic context. Client change was similar, with variations of uniqueness; as well as being different according to the individual.

Methodological Implications

As the foregoing discussion has suggested (especially in Chapter III), the **process approach** was selected for the study to explore and evaluate Imagery rescripting, a new treatment for survivors of childhood

sexual abuse. Stiles (1988) had proposed that progress in establishing "causal links between process and outcome may require a deeper understanding of the process itself and development of new theories and measures." (p. 33)

As noted earlier by Czogalik and Russell (1994) there is a low value placed on process studies by psychotherapy researchers, but according to these authors, the mission of process studies is to address **practical issues** of **cure**, **accountability** and **cost-effectiveness,** as in this study. Blending both quantitative and qualitative research methods made it possible to ground scientific explanations in the life experiences, therapeutic experience and interactive therapeutic dialogue of the research participants; as well as to encourage knowledge to emerge. Czogalik's standardized instrument was chosen because of his process research program conceptualized in the therapist's interactive use of language and useful for understanding the discourse in general and in particular, using Imagery Rescripting treatment. This process approach including Czogalik's multiperspective scale, was chosen to provide the social work profession with conceptual research foundations in the education of practitioners, with an approach which can generate relevant information for making practice decisions.

In this study the most evident methodological issues of the quantitative effort relate to the following: (a) two raters, instead of three dealing with qualitative categories; (b) need for further refinement of master judgments and criteria in the coding process of the quantitative piece. It must also be recognized that the choice of the specific instrument, plan of administration, and final interpretation are reflections of the researcher's biases. This researcher has not "accepted the myth of research objectivity" (Heineman Peiper, 1989, p. 21).

Furthermore, the qualitative analysis of therapeutic interviews, and accompanying written therapist data during the session, inevitably incorporated biases as well. These biases relate principally to features such as the use of only one other reviewer of the qualitative portion of the research. Finally, another bias would be the investigator's research-focus as an influence on the other rater, as well as upon the final interpretation of the transcribed interviews.

Using both **quantitative and qualitative methods**, each with its own set of biases, a concerted effort was made to secure the most comprehensive answers possible to the research questions as stated in Chapter 1 and throughout the study.

A multivariate, replicated, case study, repeated measures design and P-technique factor analysis was used in trying to secure a quantitative

portrayal of intraindividual change within the therapist participation throughout therapy and patterns of systematic change for each individual studied (Adapted from Jones and Nesselroade, 1990, and Yin, R., 1994). This approach has great implications for fine-grained process analysis studies.

As discussed in the literature review, Beutler and Hill (1992) described some methodological issues specific to process and outcome research for studying adult survivors of sexual abuse. They assumed that treatment processes and outcomes are influenced by **input variables** and **extra-therapy events**, such as client / therapist coping styles and personality rather than demographic characteristics (This study did not have the availability of demographic statistics). In survivor studies Beutler and Hill (1992) recommended that the therapist have experience with abuse-focused therapy; other variables were client distress levels; client and therapist expectations for treatment and previous client sexual experience. The authors further contended that the effectiveness of therapy techniques may be influenced by factors such as therapist and client variables, stage of treatment, timing, and quality of intervention.

The methodological implications of this study for social workers and other researchers are that a combination of quantitative and qualitative research methods incorporated into more sophisticated and cutting edge

methodology based on theory, can bridge the gap between practice research, and education.

Significance For Clinical Social Work Practice

The significance of this research for clinical social worker practice is evident in the women's therapeutic dialogue and testimony of positive change in their ongoing recovery from incest, due to their experience of Imagery Rescripting therapy.

These women felt they had made substantial progress in their therapeutic work, and readily named dealing with their traumatic memories and restructuring them in self-nurturing imagery as useful.

With reference to the specific findings related to the issue of clinical social work practice with survivors of incest and the current research methodology, a number of important conclusions emerge. First, pieces of this research can be readily implemented within the context of practice by a qualified social worker. Since social workers may have videotapes of therapeutic interviews available for analysis, a replicated project of this study may be done with the same therapy model or another treatment model, with improvement on the study's limitations.

It is clear that social work practitioners, employing an appropriate variety of quantitative and qualitative methods similar to those used in this

study and related to their particular questions, can broaden the knowledge base of their fields of practice.

Another important conclusion is that this research has shown the extent to which research and practice are mutually supportive of, and necessary to one another, as well as suggesting that neither alone is sufficient. For example, consider what meanings that research findings related to Imagery Rescripting and Incest have if they are considered out of context, that is, simply as factors of some external reality without any reference to a specific practice base. These so called facts have limited use without environmental, real life context and without practice situations where they can be applied.

On the other hand, consider the situation of social work practice not informed by a rich, contextual knowledge base. Such a practice is based on assumptions, many of which may not be correctly applied to the immediate practice situation. This is practice readily in need of concepts relevant to the situation, which can be understood by using **multivariate, evaluative process research**.

As was noted in Chapter 1, one of the significant implications of this study is the blending of social work research and practice within the broader field of social work practice.

The most important contribution of this process study was to fulfill

its scientific mission by addressing the practical issues of **clinical effectiveness**, **accountability**, and **cost-effectiveness** of Imagery Rescripting therapy for adult women survivors of traumatic incest in the current socioeconomic-political context of the United States.

Conclusions

The women in this study provided the following four important insights for victimization and psychotherapy research and practice:

1) The research on traumatic memory (Van der Kolk and Van der Hart, 1981) was pertinent to the women's experience. Essentially, no other previous therapy for them, except Imagery Rescripting, was able to access their original trauma; re-experience and re-process their latent feelings, thoughts and behaviors at the exact age of the occurring trauma(s), with the benefit of their current adult self. In middle therapy, these are "Dolly's" own words - "For 35 years I felt these screams have been in my head. In other therapy I talked about the screams in my head and I've done alot of crying and breaking down but never did I actually feel 6 years old and able to get the crying and feelings and screams out." (p. 40)

2) The women witnessed to the effective emotional processing of their traumatic incest through (IR) by having a reduction of debilitating PTSD symptoms; some changed abuse-related schemas, growth in self-calm and self-nurturing skills, and the hope for a better future. In "Kathy's" own words - "I don't feel the guilt, fear and shame like when I was abused and I want to

do so many things I haven't done. I'd like to please myself instead of everyone else." (p. 59)

3) The women valued and benefitted, or were hindered in their development, by human connections within their family, cultural, and therapeutic context.

4) The women were able in nine sessions of Imagery Rescripting therapy to experience relief from years of intrusive memories and recurring nightmares; to confront and deal with their emotional pain, rather than deny, avoid or dissociate from it, and have new hope in living wholistically into the future.

Recommendations

Based on the study's findings, implications and conclusions, the following recommendations can be made:

First, clinical social workers can use the developing model of **Imagery Rescripting** treatment as a **brief, clincially effective and cost-effective therapy for adult survivors of traumatic incest** to reduce PTSD symptoms; change abuse-related schemas for adaptive ones and enhance their capacity for self-comfort and nurturance.

Second, social work clinicians may experiment with the use of **process research** in the exploration and evaluation of treatment interventions, while

respecting the uniqueness of client stories and individual differences in the therapeutic context.

Third, social work education should better equip its graduates for clinical practice by providing them with wider exposure to study of traumatic stress, it's victim populations and some treatment interventions with the populations.

Fourth, social work may integrate **multiculturalism** within research-informed practice by experimenting with treatment models such as Imagery Rescripting and cultures which tend to use imagery naturally in their orientation toward life.

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APPENDICES

APPENDIX A

Stuttgart Interactional Category System / 2

Appendix A

Stuttgart Interactional Category System / 2
Mode of Involvement

1. Positive Evaluation: A value judgments given and it is positive (e.g., "The movie was great").
2. Negative Evaluation: A value judgment is given and it is negative (e.g., "The movie was terrible").
3. Neutral Description: A description is given and it is neutral (e.g., "The movie was two hours long").
4. Cognitive Appraisal: An event is presented and explicitly appraised in thought and/or perception (e.g., "I could see the development of the movie's main theme").
5. Positive Affect: A feeling is expressed and it is positive (e.g., "The movie made me feel happy").
6. Negative Affect: A feeling is expressed and it is negative (e.g., "The movie made me feel angry").
7. Minimal Display of Involvement: Minimal verbal and/or vocal display is presented (e.g., "Mhm").

Conversational Techniques (or Speech Acts)

1. Reflecting: The speaker mirrors or repeats previous verbalizations (e.g., "The movie was frightening" is responded to be "You were scared by the movie").
2. Informing: The speaker provides or attempts to obtain information (e.g., "The movie had five main characters").
3. Interpreting: The speaker applies concepts to understand experience (e.g., "The problems the movie awakened in me seem centered around oedipal issues").
4. Advising: The speaker gives guidance, instruction, or advice (e.g., "You should go to the movie to relax").
5. Confronting: The speaker challenges the coherence, logic, value, etceteras, of a presented position (e.g., "You say you hated the movie, but you seem to have been enthralled by it").
6. Disclosing: The speaker reveals personal or private information (e.g., "The movie made me feel hopeless").
7. Exploring: The speaker explores, sifts through, or weights his/her experience (e.g., "I wonder why the movie made me feel hopeless").
8. Comprehending: The speaker approaches an understanding of experience as in achieving insight (e.g., "I felt hopeless because the movie awakened long forgotten problems of mine").

9. Fantasizing: The speaker refers to imagined persons, laces, or things (e.g., "The movie made me think that I could be Peter Pan and have a happy life in Never Never Land").
10. Minimal Technical Activity: The speaker engages in minimal conversational techniques (e.g., "Oh").

Conversational Regulation

1. Initiating: The speaker introduces a new topic, perspective, or focus (e.g., "Let's speak now about the movie").
2. Directing: The speaker makes explicit demands of the conversational partner (e.g., "Stop your criticism of the movie").
3. Continuing: The speaker addresses the conversational topic without explicitly shaping its direction
   (e.g., "I went to the movie last night" is responded to be "I also went to the movie").
4. Affirming: The speaker explicitly reinforces and/or generally supports the preceding utterance
   (e.g., "I enjoyed the movie." is responded to by "Yes, I too thought the movie was enjoyable").

5. Disaffirming: The speaker explicitly negates, ignores, and/or generally does not support the preceding utterance (e.g., "I enjoyed the movie." is responded to by "No, I didn't think the movie was very enjoyable").
6. Questioning: The speaker formulates an explicit question (e.g., "How did you like the movies?").
7. Answering: The speaker formulates an answer to a question or a directive (e.g., "How many people were at the movie?" is responded to by "There were 50 people at the movie").
8. Back Channel Regulators: Minimal verbal or vocal conversational regulation (e.g., "Yes").

Temporal Orientation

1. Distant Past Orientation: The speaker talks about events in the distant past (e.g., "In my childhood, I loved movies").
2. Recent Past Orientation: The speaker talks about events in the recent past (e.g., "I went to the movies last week").
3. Present Orientation: The speaker talks about events in the present (e.g., "I like going to the movie").
4. Future Orientation: The speaker talks about events that are to occur in the future (e.g., "I will want to go to the movies more when I am retired").

5. Lacking Indication of Temporal Orientation: The speakers utterance lacks indications of temporal orientation (e.g., "OK").

Content

1. Therapy parameters: The utterance concerns aspects of the therapy (e.g., "Is our session at 5:50 P.M.?").
2. The Person of the Therapist: The utterance concerns the patient (e.g., "Mr. _____ do you have children?").
3. The Persons of the Patient: The utterance concerns the patient (e.g., "Mr. _____, have you a headache again today?").
4. Significant Others: The utterance concerns individuals of primary importance to the speaker or hearer (e.g., "Mr. _____, has your wife returned home as yet?").
5. Nonsignificant Others: The utterance concerns individuals of incidental importance to the speaker or hearer (e.g., "The fourth cousin on my mother's side also was named after Napoleon").
6. Work or Leisure: The utterance concerns events taking place in the work (e.g., vocational or educational) context and/or in recreational contexts (e.g., "We went to the beach and had a picnic").

7. Objective Events: The utterance concerns public events and is focused on the objective parameters (e.g., "The bridge to the island was being repaired and we took an alternate route").
8. Therapist-Patient Interpersonal Relationship: the utterance focuses on the relationship between the therapist and patient (e.g., "When you groan at me like that I think you feel I am inadequate and unworthy").
9. Significant Others - Patient Interpersonal Relationship: The utterance focuses on the relationship between the patient and significant others (e.g., "My sister always depends on me and it strains our relationship").
10. Nonsignficant Other - Patient Interpersonal Relationship: The utterance focuses on the relationship between the patient and nonsignificant others (e.g., "I told the delivery man I was angry at him, and he told me to get off his back!").
11. Contentless Verbalizations: There is insufficient verbalization to determine the context of the utterance (e.g., a sigh, or "Hmm").

APPENDIX B

Therapist Session Form

Therapist Session Form - (1992)

Name of Therapist: _____ Date: _____

Client Number: _____ Session Number: _____

Inspection of Homework Assignment:

How much time was spent on homework? _____

Compliance Problems/Comments: _____

_____

_____

Description of Exposure in Imagination: _____

_____

_____

Ratings During Imaginal Exposure: (Subjective Units of Discomfort 0-00)

Beginning (SUDS) _____
5 minutes (SUDS) _____
10 minutes (SUDS) _____
15 minutes (SUDS) _____
20 minutes (SUDS) _____
25 minutes (SUDS) _____
30 minutes (SUDS) _____
35 minutes (SUD) _____
40 minutes (SUD) _____
45 minutes (SUD) _____
50 minutes (SUD) _____
55 minutes (SUD) _____
60 minutes (SUD) _____

Comments: _____

_____

Subject Unit of difficulty (SUD) - 0-100

0 = not at all difficult (he went away immediately)
100 = not able to chase him away

Rating: _____

Subject Unit of Difficulty (SUD)
Adult Nurturing Child - 0-100

0 = not at all difficult to nurture child
100 = unable to nurture child at all

Rating: _____

APPENDIX C

Rating Chart for the (SICS) Instrument and Code Book

		STUTTGART	INTERACTIONAL	CATEGORY SYSTEM/2		
A-Mode of Involvement	B-Speech Acts	B-Speech Acts - (cont.)	C-Speech Regulation	D-Temporality	E-Content	E-Content (Cont.)
1 POSITIVE EVALUATION A positive value judgment ("The movie was great.")	1 REFLECTING Speaker repeats words or mirrors them ("The movie was frightening, you were scared by the movie.")	7 EXPLORING Speaker sifts through client's experience ("I wonder why the movie made you feel angry.")	1 INITIATING Speaker introduces new focus, topic or perspective ("Let's talk about work.")	1 DISTANT PAST Speaker talks about events in past ("When I was in school I enjoyed studying.")	1 THERAPY PARAMETERS Speaker's utterance concerns aspects of the therapy ("Is our session at 5:00?")	7 OBJECTIVE EVENTS Utterance concerns public events & focused on their objective parameters. ("The road was closed so I detoured.")
2 NEGATIVE EVALUATION A negative value judgment ("That actor was terrible.")	2 INFORMING Speaker gives or tries to get information ("The movie had 5 main characters.")	8 COMPREHENDING Speaker comes to an understanding of experience as in getting insight ("I got a voice from doing our therapy together.")	2 DIRECTING Speaker makes explicit demands of client ("When you're ready shall we do imagery.")	2 RECENT PAST Speaker talks about events in recent past ("I forgot to tell you this last week.")	2 PERSON OF THE THERAPIST The utterance concerns the therapist ("Dr. do you have children?")	8 THERAPIST-CLIENT RELATIONSHIP Utterance is on the relationship between therapist & client ("You taught me to have a voice.")
3 NEUTRAL DESCRIPTION Neither positive or negative ("The movie was two hours long.")	3 INTERPRETING Speaker applies ideas to understand experience ("The movie stimulated my oedipal issues.")	9 FANTASIZING Speaker refers to imagined persons, places or things ("I would like to play outside all the time, but know I must enter the house where I was abused.")	3 CONTINUING Speaker addresses conversation without shaping direction ("I also saw the movie.")	3 PRESENT ORIENTATION Speaker talks about events in the present ("You are smiling alot.")	3 PERSON OF THE CLIENT Utterance concerns the client ("Mrs. ____, do you have a headache?")	9 SIGNIFICANT OTHERS CLIENT INTERPERSONAL RELATIONSHIP Focuses on relationship between client & significant others ("my mother rejected me.")
4 COGNITIVE APPRAISAL Appraisal in thought and/or perception ("I see the movie's development.")	4 ADVISING Speaker gives guidance, instruction, advice ("Go to the movie for fun.")	10 MINIMAL TECHNICAL ACTIVITY Speaker engages in minimal conversational techniques ("oh")	4 AFFIRMING Speaker supports the client ("You write well.")	4 FUTURE ORIENTATION Speaker talks about events that will occur in the future ("This therapy will help to relieve your flashbacks.")	4 SIGNIFICANT OTHERS Utterance concerns individual of primary importance to the speaker or hearer. ("Mrs. has your father invited you?")	10 NONSIGNIFICANT OTHER-CLIENT INTERPERSONAL RELATIONSHIP Relationship between client & nonsignificant others ("Strangers were laughing at me.")
5 POSITIVE AFFECT Positively expressed feeling ("The movie made me happy.")	5 CONFRONTING Speaker challenges ("You say you hated the movie, but you seemed excited about it.")		5 DISAFFIRMING Speaker negates, ignores or does not support ("You are not welcome here.")	5 LACK OF TEMPORALITY Speaker's utterance lacks indications of temporal orientation ("ok")	5 NONSIGNIFICANT OTHERS Utterance concerns individual of incidental importance to the speaker or hearer ("My 4th maternal cousin was named Ceasar.")	11 CONTENTLESS WORDS Not enough words for content ("Hmm or sigh")
6 NEGATIVE AFFECT Negatively expressed feeling ("The movie made me angry.")	6 DISCLOSING Speaker reveals personal nformation ("The movie made me feel hopeless.")		6 QUESTIONING Speaker formulates a ? ("How does your adult respond?")		6 WORK OF LEISURE Utterance concerns events in work context or recreation ("You went up north for the weekend.")	
7 MINIMAL INVOLVEMENT Little verbal and/or vocal display ("Mhm")			7 ANSWERING Speaker formulates an answer to a question or a directive ("You will be helped to deal with flashbacks.")			
			8 BACK CHANNEL REGULATORS Minimal verbal regulation ("Yes")			

Code Book

These criteria were used in the coding process by the Raters to establish consistency in the system of categorization of therapist variables.

1) Not more than 3 categories in each class.

2) Is that right? -**C6, D3, B10**

3) Tenses D3 → present → is, are, can, have, has, do, go
→ past → was, were, did, could
→ future → will, if,

4) Fantasizing - adult and child = **B9**

5) "I suggest" = usually = **B4**

6) "I think" = usually = **A4** or **B8**

7) You (client) = **E3**

8) "Let's. . " = usually = **C1** & **E8**

9) If both therapist and client = **E8**

10) If both client and significant others = **E9**

11) Mm or Hmm alone = **E11, A7, B10**

12) If mm, or hmm with other words = disregard mm or hmm

13) A how question = usually = **B7**

14) Usually a question with one or two word answers = **B2**

15) Confronting or challenging - BUT or discrepancy = **B5**

16) An exploring what question = **B7**

17) Challenging - "Can you see yourself doing that?" = **B5**

18) For "Mm or oh or okay", alone = **A7, B10, C8, D5, E11**

19) "Yes", or "Yeah" = **C7, C8, if affirming C4**

20) "Any other thoughts or feelings?" = **B7**, exploring

21) We imply person lie in "Go, ahead - meaning You" = **E3**

22) "Level of distress?" = **A6 & E1**

23) "are going to _____" = **D4**

24) "What happens next?" = **D4**

25) "Can you **see** yourself doing that to him?" = **B5, B9, C6, E9**

26) "Go back to the car scene." = **D2**

APPENDIX D

Participant Consent Documentation

Cognitive Therapy Institute of Milwaukee

1220 Dewey Avenue
Wauwatosa, Wisconsin 53213
(414) 454-6620

Mervin R. Smucker, PhD.
Director

November 20, 1995

Loyola University of Chicago
School of Social Work
Attention: Joseph Walsh, Ph.D.
820 N. Michigan Avenue
Chicago, IL 60611

Dear Dr. Walsh:

This letter is to verify that the two subjects from my outcome study of 1993, whose videotapes Carmen Agbuis will use for her dissertation have authorized this use. Carmen may use them for her research and subsequent educational presentations. It is recognized that Carmen will take all necessary cautions for client privacy and confidentiality.

Please not hesitate to call me at (414) 454-6620 if you any questions.

Sincerely yours,

Mervin R. Smucker, Ph.D.

MS/ah