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PERCEPTIONS OF ALLEGED SEXUAL ASSAULT DURING THERAPY

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This study investigated how people perceive the relevance of selected factors in situations of alleged sexual assault during therapy. We focused on the extent to which the presence or absence of hypnosis, the use of force, and client involvement influenced participants' perceptions of constructed cases of sexual assault. Sixty-four individuals read vignettes in which the presence or absence of these factors was manipulated, and they made ratings and judgments about the responsibility, control, and guilt of both therapist and client. When hypnosis was used, participants perceived the client as less responsible and having less control, and the therapist as more responsible. The presence of force led participants to perceive the client as being less responsible for the events; however, when the client was involved in the sexual activity she was perceived as being more responsible and as having more control. These findings are discussed in terms of the general public's perceptions and beliefs about hypnosis and sexual assault, as well as their views of the nature of a therapeutic relationship and the responsibilities of a therapist.

How people perceive sexual assault during therapy has not been investigated systematically. In such cases, there will be numerous influences on a person or juror's decision as to who or what was responsible for the sexual assault. Hoencamp (1990), for example, argued that factors such as the emotional intensity of the therapeutic relationship, the abuse of authority, the presence of drugs or alcohol, the use of verbal coercion and/or techniques such as hypnosis, the use of physical force, and whether the client becomes actively involved in the sexual act would all influence views about coercive "power"

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in a therapeutic setting. Our study investigated the relevance of selected factors in a situation of alleged sexual assault, or "sexual coercion in a therapeutic setting." We sought to examine the extent to which these selected factors influenced views about the contributory responsibility, control, and guilt of both therapist and client.

People's perceptions about the factors that may be involved in events such as sexual assault will differ depending on their expectations of, and interactions with, the world (Coates, 1997). If physical coercion is involved, then people may perceive the victim as having less control. However, if there is a power imbalance between the two people involved (such as between a therapist and a client), then verbal coercion or persuasion may be seen to be just as powerful as physical coercion (Hoencamp, 1990). Alternatively, if only verbal coercion is used then people may perceive that a client should be able to exert control when "only words," rather than physical force, are used. The importance that people attach to the use of physical force will be influenced by perceptions of whether the use of force necessarily constitutes sexual assault; the use of force may not be seen to be as important as other factors such as implied consent, as in cases of date rape (Sawyer, Pinciaro, & Jessell, 1998).

The type and degree of client involvement in the event may also influence people's perceptions of responsibility and guilt (McConkey & Sheehan, 1995). For instance, people may attribute responsibility to both parties if therapist and client are both active during the sexual act, rather than if the client is passive. However, if the client is passive in the sense that she simply "lies still" during the sexual act, then people may perceive that she is allowing the act to occur. People perceive a woman who either is actively involved in, or who does not resist, a sexual act as essentially consenting to the act. Relatedly, people perceive an alleged rapist as more guilty and attribute less blame to the victim if she verbally or physically resists (Warner & Hewitt, 1993).

A longstanding debate in this area is the role of hypnosis in sexual activity between the rapist and client, and this debate has revolved around beliefs about the effect of hypnosis on voluntariness, control, and capacity to consent (Hoencamp, 1990). Although there is substantial evidence that hypnosis cannot be used to "force" someone to engage in acts against their will (Wagstaff, 1999), McConkey and Sheehan (1995) suggested that when other persuasive influences occur in conjunction with hypnosis, empirical findings that people do not act "against their will" during hypnosis cannot be so easily

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applied. Also, they emphasised the importance of considering an abuse of trust between therapist and client that results in sex as a distinct category of "hypnotic coercion." Hypnosis was one focus of our study because various (Kline, 1972; Perry, 1979) clinical cases appear to show that hypnosis can be used to "coerce" sexual activity (Kline, 1972; Perry, 1979). At the very least, hypnosis may heighten processes, such as transference, that can influence coercive behaviour or response to coercion (Orne, 1972).

Sexual assault has occurred in various therapeutic relationships and factors such as physical force, client participation, and hypnosis have been said to play a significant role, as highlighted by various case studies (e.g., see Conn, 1972; Hartland, 1974; Hoencamp, 1990; Judd, Burrows, & Bartholomew, 1986; Kline, 1972; Laurence & Perry, 1988; McConkey & Sheehan, 1995; Perry, 1979, 1992; Venn, 1988). Hoencamp (1990) documented how several clients in the Netherlands went along with a (hypno) therapist's sexual activity because they thought it must be normal treatment. Perry (1979) reported an Australian case of alleged sexual assault in which the victims were, to some degree, active participants. A lay hypnotist, Palmer, met three women at a party where he demonstrated hypnotic techniques; on subsequent occasions he had sexual contact with them during hypnosis (Perry, 1979, 1992). Palmer claimed that the women engaged actively in sexual relations and one of them admitted that she had masturbated Palmer. The women claimed either no recollection of the sexual contact or that they were aware but could not resist. Also in Australia, Judd et al. (1986) reported two cases where the victims were passive. In *R v. Davies*, a client testified that she was aware of what was occurring during hypnotherapy but she did not object: "as far as I was concerned when he said 'I'm only touching your stomach,' my stomach would tingle and I would think 'Yes, he's only touching my stomach,'" when in fact he was sexually assaulting her. McConkey and Sheehan (1995) reported a case in which a taxi driver who had knowledge of hypnotic techniques allegedly committed sexual assault on a hypnotised woman. The woman initially recalled nothing of this particular interaction, but subsequently recalled the taxi driver saying her arms would become heavy during hypnosis and she would not want to move them.

Cases such as these lead to a focus on three specific factors — hypnosis, force, and client involvement. In our study, we presented participants with vignettes involving alleged sexual assault in a therapeutic setting and asked them to make ratings and judgments based on the information they were given. By manipulating the presence or absence of hypnosis, force, and client

involvement we determined how these factors were perceived. We used four vignettes because this was the minimum needed to make three planned comparisons: hypnosis versus no hypnosis, force versus no force, and client's active versus passive involvement. Throughout the four scenarios we held the therapeutic relationship constant, with a male therapist and female client because this reflects most cases.

We asked participants to rate the responsibility, control, and guilt of the therapist and client in each scenario. By looking at the planned comparisons in relation to these ratings we investigated whether the presence of hypnosis, the use of force by the therapist, and the client's type of involvement separately influenced the way in which people perceived the events. Because the context was a therapeutic setting, we anticipated that participants would rate the therapist higher than the client on the measures of responsibility and control. We expected that the presence of hypnosis and/or force would result in lower ratings of responsibility and control for the client, compared to scenarios in which these factors were absent. Also, we expected that the client's active involvement would lead to higher ratings of client responsibility and control compared to when she was passive. In regards to the therapist, we predicted that hypnosis and force would lead to the therapist being seen as more responsible and in control of the events as compared to when these factors were absent. Conversely, we predicted that responsibility and control would be lower for the therapist when the client was active than when she was passive. Finally, we expected that the use of hypnosis and/or force would lead to deciding the therapist was "guilty" whereas the client's active involvement would lead to a higher rate of "not guilty" decisions.

METHOD

Participants

Sixty-four (34 male and 30 female) individuals in the age range 18–65 years ($M = 32.89$, $SD = 12.70$) were selected randomly from the general public and took part in the study voluntarily. These individuals were from a variety of backgrounds and occupations and were approached by the investigators and their associates to take part in research involving judgments about events associated with therapy. Ninety-eight people were approached in their homes and workplaces and 64 (i.e., 65%) agreed to complete the questionnaire.

Questionnaire

The questionnaire was administered to participants three times, and they were told to respond to the scenarios in a consistent manner. There were four vignettes, each presented in a different order (AB, BA, independent variables: force, and client involvement). In each vignette, physical force was present, physical force was absent, and hypnosis was present. Scenario D hypnosis was active. Every vignette was presented in a different relationship, the admission of the therapist, and the exceptions of the

¹ The four vignettes were independent variables: ages, and presenting problems. Linda Jones, a 28-year-old woman in private practice, was presenting problems in her sessions, Gary used these techniques in these sessions, saying "You are not guilty" that Linda was not guilty. She had not penetrated her. Linda started to cry from the fourth session. Linda started to cry she had experienced this before. She decided to call the police and there was a police officer that the sex was not consensual encounter and st

Questionnaire

The questionnaire was developed for this study. The cover sheet informed participants they would be presented with scenarios based on events that occurred in therapy. They were asked to read each of the four scenarios at least three times, and then to make ratings and judgments about the events. They were told to respond only to the evidence in the scenario and to read and rate the scenarios in the order presented. Four vignettes were developed and used.¹ There were four different orders (ABCD, BDAC, CADB, DCBA) of presentation and participants were assigned randomly to one of the four version orders; approximately equal numbers of participants were tested in each order (ABCD = 16, BDAC = 17, CADB = 15, DCBA = 16). Three independent variables were manipulated in the scenarios: hypnosis, physical force, and client's involvement. In Scenario A hypnosis was absent, physical force was absent, and the client was active; in Scenario B hypnosis was present, physical force was present, and the client was passive; in Scenario C hypnosis was present, physical force was absent, and the client was passive; and, in Scenario D hypnosis was present, physical force was absent, and the client was active. Every other aspect of the vignettes was similar (i.e., therapeutic relationship, the client's response following the events, and the therapist's admission of the sexual encounter stating it was consensual) with the exceptions of names, ages and presenting problem (depression or anxiety),

¹ The four vignettes took the following form, with the presence or absence of the three independent variables manipulated and other aspects held constant, with the exceptions of names, ages, and presenting problem (Scenario B — hypnosis present, force present, client passive):

Linda Jones, a 27-year-old single woman, had been experiencing anxiety for some months. After talking to a friend Linda sought help from Gary Harvey, a 34-year-old psychologist in private practice in the suburb where Linda lived. At the first session they discussed the presenting problem and Linda felt that Gary could indeed help her. At the second and third sessions, Gary used hypnotic techniques to help her relax and explained that he commonly used these techniques to alleviate emotional difficulties, along with other counselling methods. The events in question allegedly took place at the fourth session, during hypnosis. Linda recalls Gary saying "You are feeling very attracted to me and we are going to have sex today." Gary stated that Linda was not active during sexual intercourse but "just lay there" and said nothing as he penetrated her. According to Linda's statement of complaint she could not remember much from the fourth session until she arrived home. When her flatmate asked, "Are you alright?" Linda started to cry. After going into her bedroom Linda felt physically ill at the thought that she had experienced sexual intercourse with her therapist. After talking to her flatmate she decided to call the police. Medical examination confirmed that sexual intercourse had taken place and there was evidence of physical force consistent with being held down. Linda reported that the sex was not consensual. When police confronted Gary he did not deny the sexual encounter and stated that the sex was consensual.

which varied slightly across the scenarios. The design allowed three planned comparisons: hypnosis versus no hypnosis (Scenario A versus D); force versus no force (Scenario B versus C); and, the client's active versus passive involvement (Scenario C versus D).

Four questions regarding the therapist's and client's responsibility and control in each scenario followed each vignette. Ratings on these items were on a 10-point Likert scale where 1 = not at all and 10 = completely. Also, participants were asked whether they would find the therapist guilty of sexual assault (yes or no) if they were acting as a juror in court. They were then asked via an open-ended question to list the three main factors that influenced their decisions. After all four vignettes and ratings, the participants were asked if they had ever experienced hypnosis.

RESULTS

Initial analyses indicated that the order of presentation, sex of participants, and the participants' experience with hypnosis did not influence the pattern of ratings. Thus, these variables were not considered further. Table 1 presents the mean ratings of responsibility and control, and the percentage of guilty verdicts.

For the planned comparisons of hypnosis (Scenario A versus D), force (Scenario B versus C), and involvement (Scenario C versus D), paired *t*-tests were conducted to compare ratings of the 10-point scales for responsibility and control. For Scenario A versus D (no hypnosis versus hypnosis), the

Table 1: Mean Ratings of Responsibility and Control for Therapist and Client, and Percentage of Guilty Verdict for Therapist

	Scenario			
	A	B	C	D
Therapist				
Responsibility	9.13 (1.35)	9.72 (1.06)	9.75 (0.59)	9.66 (0.70)
Control	9.72 (0.65)	9.86 (0.30)	9.86 (0.30)	9.81 (0.50)
Guilty Verdict	53.1%	96.9%	92.2%	85.9%
Client				
Responsibility	4.27 (2.90)	1.69 (1.11)	1.97 (1.39)	2.52 (1.12)
Control	4.86 (2.88)	2.06 (1.47)	2.27 (1.75)	2.69 (2.30)

Note. For ratings of responsibility and control, 1 = not at all and 10 = completely. Standard deviations appear in parentheses.

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responsibility attributed to the therapist was higher when hypnosis was present, $t(63) = 3.41, p < .001$. There was no difference in ratings of control for the therapist between these scenarios. Further, a lower level of responsibility, $t(63) = 5.35, p < .001$ and control, $t(63) = 6.14, p < .001$ was attributed to the client when hypnosis was present. Participants were more likely to find the therapist guilty when hypnosis was present rather than absent, $\chi^2(1, N = 128) = 16.26, p < .001$. For Scenario B versus C (force versus no force), the comparison of responsibility and control for the therapist between the scenarios was not significant. When force was present, participants gave a lower rating of responsibility but not control for the client, $t(63) = 2.94, p < .01$. There was no significant difference in the rate of guilty verdicts between these scenarios; that is, the presence or absence of force did not influence perceptions of the therapist's guilt. For Scenario C versus D (passive versus active involvement), when the client was active rather than passive in the sexual activity, the ratings were not significantly different for the therapist. However, the client was seen as more responsible, $t(63) = 3.31, p < .01$, and more in control, $t(63) = 2.47, p < .05$, when she was active. The difference between the guilty verdicts for Scenarios C and D was not significant; that is, the level of involvement of the client did not influence perceptions of the therapist's guilt.

A consideration of the responses to the open-ended question ("What are the three main factors that influenced your decision/guilt?") indicated that participants frequently mentioned factors to do with hypnosis, use of force, and the client's involvement, as well as the therapeutic relationship itself, as the factors that influenced their decision. For example, comments included "his conduct was unethical he abused her trust," "he used a position of power for his own purpose," "under hypnosis she had no control," "you can instruct people to behave a certain way under hypnosis," "no force suggests consent," "her silence implied acceptance," and "it was mutual because of her active participation." A theme in these comments was that the breach of the therapeutic relationship itself was a major factor in determining the therapist's guilt.

DISCUSSION

We investigated people's perceptions of hypnosis, force, and client involvement in constructed cases of sexual assault in therapy. We found that when hypnosis was used participants perceived the client as less responsible

and having less control, and the therapist as more responsible. Further, the therapist was more likely to be seen as guilty of sexual assault when hypnosis was present rather than absent. Inferences drawn from the findings and supported by participants' comments indicated that hypnosis was seen to cause a person to lose control and that behaviour can be dictated during hypnosis. The presence of force led participants to perceive the client as being less responsible for the events; however, when the client was involved in the sexual activity she was perceived as being more responsible and as having more control. Notably, participants rated the therapist as having more control and responsibility than the client over the events in every scenario, regardless of the manipulation of the variables. This reflects the overriding influence of the perception of therapeutic responsibility.

Our findings indicate that people's perceptions of the given events were influenced greatly by the therapeutic context. This is consistent with available case studies, which suggest that when sexual activity occurs in therapy (whether "consensual" or not) it is perceived not only by the "victim," but also by third parties, as occurring primarily because of the power imbalance between therapist and client. Hartland (1974), for instance, documented a case in which a woman alleged she had been sexually assaulted by an obstetrician who had used hypnosis. She claimed that during an examination she had not been hypnotised as he intended, but she had complied with the doctor's suggestions because she was terrified of him. As in the Palmer case (Perry, 1979), the relationship in the vignettes that we constructed was not intensely emotional or long-term. Nevertheless, our participants perceived the sexual activity as a "betrayal" of therapeutic trust as reflected in their comments to the open-ended question. That a trust had been violated was one of the most salient factors in the present research, and this supports McConkey and Sheehan's (1995) distinction of the special nature of "coercion" in therapy whether hypnotic or not. Future research could usefully examine the differences between sexual activity scenarios that occur in therapy and those that occur in contexts that do not have a "duty of care."

Over and above the therapeutic context, one major finding was the strong effect of the presence of hypnosis. The therapist was viewed as more culpable when hypnosis was employed than when it was not. Many participants believed that the therapist took "total control" over the client when he used hypnosis. This is consistent with the general public view that hypnosis causes loss of control and involuntariness, but is not consistent with scientific findings

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about hypnosis (Labelle, Lamarche, & Laurence, 1990; McConkey & Jupp, 1985; Perry, 1992; Spanos, Gwynn, & Terrade, 1989; Wagstaff, 1999; Wagstaff, Green, & Somers, 1997). Until now, however, there has been little research on people's perceptions of crimes committed against a hypnotised person. Consistent with Wagstaff et al. (1997), our findings support previous data that people perceive a person to be less responsible for their actions during hypnosis. This implies that, despite empirical indications to the contrary (Laurence & Perry, 1988; McConkey & Sheehan, 1995; Perry, 1979), participants perceive hypnosis as significant in determining role responsibilities.

Force was seen to be relevant over and above the factors of hypnosis and the therapeutic setting. Whereas the number of guilty verdicts was no different between the force and no-force scenarios, the ratings suggest that the client was seen as less responsible when coerced by physical rather than by verbal means. Relatedly, Warner and Hewitt (1993) found that when a victim was held down and struggled during a sexual assault, people perceived the victim's consent as lower than when only verbal coercion was used (see also Sawyer et al., 1998). The placing of our scenarios within the context of therapy makes the distinction between verbal and physical coercion difficult to discern, and future research could focus on the nature of the relationship and how this might influence the ways in which different types of coercion are used.

Our study was heuristic in approach and is limited in various ways. We focused on three factors as independent variables, looked only at each in isolation, and did not examine any interaction effects among them. In addition, there may have been other factors that could have impacted differently on people's perceptions of the given event. For instance, the presence of internal motivations of the client, the intoxication of the client, or the creation of specific delusions through the use of hypnosis could have been included (McConkey & Sheehan, 1995; Perry, 1979). Also, our dependent variables may not have been adequately sensitive to the effects. One indicator of this was the presence of ceiling and floor effects. That is, in every scenario the therapist was rated as highly responsible and in control while the client was considered as having close to no responsibility. This could be overcome in future by selecting dependent variables that allow room for the measurement of differences across conditions. Our study may have been limited also by a within-subjects design. Although there was no order effect, having every participant read all four scenarios might have resulted in a

different effect than if each had only been given one scenario and the analysis was between-subjects. As only four vignettes were developed, this may have limited the findings in that the conditions of force and involvement were all contained within vignettes that involved the use of hypnosis. That is, since hypnosis had such a strong effect on participants' perceptions it may have "leaked" across their perceptions of use of force and the client's involvement. Future research could use more vignettes that involve the manipulations of force and client involvement without the use of hypnosis.

One innovation of the study was the development of vignettes and rating scales to study people's perceptions about the factors involved in events such as sexual activity in therapy. This method offers a potentially useful way of clarifying people's perceptions and casual attributions. Another strength of the study was its representativeness in the use of a community-based sample of participants as opposed to a convenience sample of undergraduate university students (see McConkey & Jupp, 1985; Wagstaff et al., 1997). Our findings show that the general public perceives hypnosis, force, and the therapeutic relationship itself, to be salient coercive mechanisms in terms of their impact on the control and responsibility of the therapist and the client in cases of alleged sexual assault in therapy. Overall, our study gives an understanding of the ways in which people perceive hypnosis, force, and client involvement in cases of sexual activity in a therapeutic setting and points us in a direction for future research.

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