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**Clinical Intervention, Supportive Counselling and Therapeutic Methods: A Clarification  
and Direction for Restorative Treatment.**

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## Abstract

There is currently some confusion regarding the provision of therapeutic options as part of a restorative treatment approach to criminal victimisation. This article aims to clarify the issues surrounding psychological debriefing, early intervention, post traumatic stress disorder and recovered memory therapy as raised by Fattah (1999; 2000). In essence, the evidence to date suggests that whilst debriefing and repressed memory therapy may in fact be detrimental to the well-being of the victim, early intervention with Cognitive Behavioural Therapy for those with identifiable disorders who request help is very effective in relieving the suffering following victimisation. It is also suggested that while 'supportive counselling' for those with transient personal problems may be of use, this has not yet been demonstrated and is definitely not of use when treating mental disorders. There is no objective evidence to suggest that 'supportive counselling', active listening by quasi-professionals or 'tea and sympathy with Aunt Adie' are effective.

The purpose of this article is to clarify the current state of knowledge relating to the provision of therapy to victims of crime. Fattah (1999; 2000), in arguing against the provision of therapeutic services, rightly raised some areas of concern regarding the effectiveness of providing therapeutic encounters for victims of crime while calling for more empirical research. However, the generalistic nature of those comments mean that a clarification of the current state of our knowledge within the clinical field is absolutely necessary should these concerns be placed within their proper context. This article will restrict itself to the issues and diagnoses that are raised by Fattah, but it is important to keep in mind that there is a range of possible psychological and non-psychological reactions following criminal victimization which are not addressed in this paper. However, before defining our terms and discussing the thrust of this article it would seem wise to firstly summarise Fattah's concerns.

In essence Fattah (1999) raised the possibility of therapy acting as a noxious rather than restorative process for victims. Whilst referring to "nocebo" (or harmful) effects of intervention, Fattah initially alludes to the process of iatrogenesis by priming and maintaining symptoms in child sexual abuse / assault cases. He refers to the process of therapy as likely to inflate the meaning of the sexual abuse within an impressionable young mind and that it is the "parents, the child welfare workers, the therapists, and the criminal justice personnel (police prosecutors, etc.) who, through their questions, attitudes and behaviour, communicate to the child that something really awful has been done to them" (p.197) and elegantly warns of the dangers of well-intentioned care. He then progresses to discuss the pitfalls of repressed-memory therapy whereby some clinicians assume a traumatic history (usually of childhood sexual abuse) in clients which initially report no such memory. Through the influences of suggestion he proposes that these clients then start to believe they were

abused, adopt the role of victim and start to pursue groundless accusations against the innocent - in effect creating yet more victims. From this Fattah raises concern for the delivery of psychological debriefing following traumatic incidents which is made available in the hope that it will mitigate long term distress and, more specifically, post traumatic stress disorder (PTSD). He points to some research along these lines which suggests that debriefing may be inert or even possibly noxious and also questions the use of terms such as PTSD, claiming that this pathologises normal reactions.

These are concerns worthy of note but by 2000 Fattah's fears appeared to have grown to the point where he claims that "despite the vested interest and enormous financial and professional benefits that a huge army of therapists currently reaps from "treating" victims, I can safely predict the demise of victim therapy in the not too distant future"(p. 41). He also states later that "alternative healing practices, which are currently competing with traditional medicine for treating physical and psychological ailments, will prove better, more effective, less harmful and much less costly than professional therapy"(p. 42). This last point is also worthy of dispute, but lies outside the realm of this article.

However, while Fattah's comments (1999) are related to specific instances, certain client groups and certain types of intervention, the warnings and fears have been generalised across all therapeutic interventions for victims of crime. But, as will be seen, the evidence does point towards a need for an understanding of how "the consequences of the victimizing event will be extremely different from one victim group to another, and from one individual victim to the other" (p. 193).

The utility of early intervention for victims of crime and civilian trauma survivors is now becoming generally clearer and we now have a greater understanding of possible reactions to crime and treatment efficacy than may have been assumed. Research to date paints a more complexly

structured and integrated picture than Fattah sees and in order to examine the veracity of Fattah's fears, and the implications for victim services, it is also necessary to offer some definitions for those readers who are not clinicians by trade. More specifically it is important to note differences between early intervention for those who request it and the panoptic provision of debriefing following trauma.

### Debriefing and Early Intervention.

Psychological Debriefing. Psychological debriefing is best described as the wholesale provision of professional services, usually by private debriefing companies / psychologists, which allow for emotional ventilation immediately following a trauma (usually within 72 hours). Debriefing is not provided only when requested by the individual, but as a matter of course following a traumatic event (e.g. earthquakes, shootings, robberies, etc.). The most commonly referred to method of debriefing is the proprietary based "Critical Incident Stress Debriefing" (CISD) which initially used predominantly group based interventions (Mitchell, 1983) and has evolved to include, amongst other strategies, individual debriefing sessions and is now sometimes referred to as "Critical Incident Stress Management" (Everly and Mitchell, 1997).

An inspection of the available data does appear to support Fattah's comments. A meta-analysis by Wessely, Rose and Bisson (1997), as part of the Cochrane Collaboration, found that poorer outcomes were sometimes associated with those who received debriefing. Since this review other studies have randomly allocated people to either receive or not receive debriefing and have likewise generally found that those who received the debriefing were more likely to develop PTSD than those who did not receive it (e.g. Mayou, Ehlers and Hobbs, 2000). This has led to a recent editorial in the British Medical Journal stating that debriefing may be doing more harm than good and that there is no evidence that one type of debriefing is any more effective than any other type

(Kenardy, 2000). This last point is also important to our field. While some argue that different models of debriefing have differential success rates (e.g. Everly, Flannery and Mitchell, 2000) this has not been demonstrated through controlled study. This is true whether the model is the CISD of Mitchell (Mitchell, 1983), the National Organization for Victims Assistance Crisis Response of Young (NOVA, 1996), or part of the Green Cross Organization of Figley (Green Cross, 2000). In fact, all the controlled studies to date show that individual debriefing does not mitigate traumatic reactions to victimisation and is, therefore, a probable misuse of resources and even harmful. For a more in-depth and reasoned look at the approaches available in response to disasters and the insidious growth and effects of 'Trauma Tourism' the reader is directed to an excellent edited book by Gist and Lubin (1999).

It is important to note, however, that in nearly all studies client satisfaction ratings showed people to be highly satisfied with debriefing and these satisfaction ratings have been bandied by advocates of various interventions as evidence for their continued use. However, this is an hysterion proteron position. Satisfaction ratings are quite often a 'popularity contest' where the client ends-up rating the pleasantry of the therapist / intervention and not the effectiveness of it. A good therapeutic intervention aims, if at all possible, to have both high satisfaction ratings and evidence of high efficacy and, hopefully, effectiveness. However, whilst high satisfaction ratings are no replacement for effectiveness, the corollary is not necessarily true - an effective treatment may be advisable even with low satisfaction.

To make sense of these points one only has to consider the use of the teratogen thalidomide during the 1960's with expectant mothers who were very "satisfied" with the resultant lack of morning nausea. Using the logic advocated by those who see satisfaction as the important variable

we should have continued the use of this drug - irrespective of the long-term effects, the effect of this drug on embryonic development. Looking at the corollary, one has only to consider chemotherapy for cancer which tends to be seen in a negative light, yet can lead to a very effective outcome. This is an important point, and one worth repeating: satisfaction, whilst desirable, does not equate to intervention potency.

Early Intervention. Early intervention to victims of crime, on the other hand, is the provision of what could be called ‘restorative treatment’ to individuals who request psychological help following crime / trauma and have a clinically significant presentation. Of course, what counts as a clinically significant presentation is open to debate, yet within Australia, Israel, and the USA this has generally meant meeting the criteria of a disorder as outlined in the Diagnostic and Statistical Manual of Mental Disorders - Version IV (DSM-IV, 1994). An important aspect to the DSM-IV is the stipulation on most disorders that “the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” and in the case of Acute Stress Disorder “or impairs the individual’s ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience” (p. 472). This was an important change from the old diagnostic manual systems where this subjective aspect was noticeable only by its omission.

Recent research studies have tended to address participants who meet the criteria for Acute Stress Disorder (ASD) by then providing a variety of treatment interventions. ASD was incorporated into the DSM-IV as a diagnosis to help predict those that were likely to go on to develop long term problems as a result of a traumatic experience, such as PTSD. We now know that untreated, and two years following the trauma, about 75% of those who have ASD progress to

PTSD. Unfortunately, it appears that the diagnostic criteria for this presentation are not yet specific enough as 70% of those with symptoms that would be classified as sub-clinical and 13% who did not meet either category also go on to develop PTSD (Bryant and Harvey, 2000). However, of importance to the current debate, and Fattah's fear of pathologising what good social support would rectify, is the issue of treatment efficacy. Is treating ASD a good thing to do? Is it any more effective than "supportive counselling" or no treatment at all? In fact, are we doing more harm than good? These questions are well worth asking, but we do now have better answers, ones supported by empirical research.

Cognitive Behaviour Therapy (CBT) is the most widely practised (by clinical psychologists) and most validated method for all psychological interventions. Controlled research into the treatment of Acute Stress Disorder has shown that those who receive CBT (a theoretical perspective which acknowledges the importance of social modelling and reinforcement principles and tends to use a plethora of researched techniques aimed at modifying beliefs and behaviour) are about 10 times less likely to have PTSD at post treatment than supportive counselling and 5.7 times less likely to develop PTSD by 6 months follow-up than if not treated at all (Byant et al., 1998; 1999). This has been demonstrated with victims of motor vehicle accidents, industrial accidents and non-sexual assault (Bryant et al., 1998; 1999), and sexual and non-sexual assault (Foa et al., 1995).

All controlled studies to date which have investigated the utility of early supportive counselling (education, non-directive support, and general problem solving) to those with Acute Stress Disorder have found it to be completely ineffective. As with CBT above, this has been demonstrated with victims of motor vehicle accidents, industrial accidents and non-sexual assault (Bryant et al., 1998; 1999).

Turning to the psychodynamic therapies, there are no controlled studies, and hence no evidence, that this method of intervention is effective with ASD. It could be assumed that psychodynamic treatments (which tend to concentrate more on issues related to family of origin and developmental history than current reinforcers for behaviour, and theoretically works by bringing the unconscious into conscious awareness, bringing about insight into the reasons for current problems and resolving psychic conflict) are supportive in nature during the early stages and hence have the same efficacy as supportive counselling for clinical conditions.

Therefore, on the basis of currently available research findings, one can see that early intervention for people who desire help and have a constellation of symptoms which meet the criteria of ASD appear to be significantly benefited by the provision of therapy. However, this has been demonstrated only with techniques which come under the umbrella of Cognitive Behavioural Therapy, and in particular, exposure therapy. Supportive counselling and psychodynamic therapies have not been found to be effective and leaving people who meet the criteria for ASD untreated shows that 80% of them will go on to develop PTSD.

#### Post Traumatic Stress Disorder.

Nature and Epidemiology. Treatments for PTSD have now been evaluated even more than treatments for ASD. In arguing for solid empirical evidence and scientific facts, Fattah (1999) notes that many interventions fail this hurdle and comments that practices such as recovered-memory therapy “stem from the popular tendency to pathologise natural symptoms and perfectly normal reactions and to fit them under new illness categories, such as posttraumatic stress disorder, that quickly find their way to the diagnostic manuals” (p. 201). However, recovered memory therapy is independent of Cognitive Behaviour Therapy and a movement very much independent of the

diagnostic category of PTSD.

PTSD is a constellation of symptoms, experienced as disturbing, which impede an individual's behaviour, thoughts and physiology to the point where these disturbances "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (DSM-IV, 1994; p.468). It is a psychological response to the experience of intense traumatic events, particularly those which threaten life, and can affect people of any age, culture or gender. Signs of this condition have been documented at least since the times of the ancient Greeks in 400 BC (Herodotus, 1972) and been described in detail by Shakespeare in Henry IV (Lady Percy's speech in part 1, scene 3). However, one could be excused lack of familiarity with the term as it has been referred to by different monikers through the ages. In the American Civil War it was referred to as "soldier's heart", in World War I it was called "shell shock", while by World War II it was known as "war neurosis". However, it should be noted that during the wars many soldiers were labelled as having "combat fatigue" when experiencing symptoms associated with what would now be called ASD during operations, and throughout the Vietnam War this became known as a "combat stress reaction". Some of these people continued on to develop what became known in the Diagnostic and Statistical Manual of Mental Disorders - Version III (DSM-III, 1980) as Posttraumatic Stress Disorder. Those presenting with what is now known as PTSD were more than likely to be classified in 1952 (DSM) under the term gross stress reaction and in 1968 (DSM-II) under temporary situational disorder (see Gersons and Carlier, 1992 for a discussion of the modern historical and political evolution of PTSD). At each stage different criteria have been applied and hence different definitions proposed. So this phenomena is not a new one and came into effect more due to the reactions of war veterans, not victims of crime.

PTSD is currently best characterised as a pathological stress response syndrome that can occur following exposure to a traumatic event, during which the individual “experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others ... [and] ... the person's response involved intense fear, helplessness, or horror” (DSM-IV, 1994). Just what constitutes a traumatic event has long been the subject of debate, particularly within the courtroom setting (e.g. Bryant, 1996; Dobson and Marshall, 1998). It would seem that the individual’s subjective perception of the event rather than the event per se is of critical importance to the later development of the behavioural and emotional symptoms associated with the diagnosis of PTSD. Because of this difficulty in objective validation the predominant method has been to look at epidemiological data with respect to specific events.

One of the best controlled investigations into the epidemiology of PTSD was that conducted as part of the American National Comorbidity Survey (Kessler, Sonnega, Bromet, Hughes and Nelson, 1995). Overall, these authors found the lifetime prevalence of experiencing any trauma to be 60.7% of men and 51.2% of women, although this does not mean that these people then went on to develop PTSD. In fact Kessler and his colleagues found that the estimated lifetime prevalence of PTSD (using DSM-III-R criteria) was 7.8%, yet also noted that this rate was higher amongst women (10.4%) than amongst men (5.0%) and was also higher amongst the previously married. The trauma most likely to be found associated with PTSD, once the person presented complaining of problems following the event, was found to be rape with 65% of men and 45.9% of women. However, it should also be noted that in Kessler’s study the women were more than seventeen times more likely than men to present with PTSD and with rape being the traumatic event.

With the exception of rape, the highest rates of PTSD following a specific trauma, and conditional upon being selected for the assessment of PTSD, for women were physical abuse (48.5%), threat with a weapon (32.6%), molestation (26.5%) and physical attack (21.3%). For males, the conditional probability of being exposed to combat and presenting with PTSD (38.8%) was the highest incidence. It should be noted, however, that this is a conditional probability and does not reflect the likelihood of developing PTSD from being in a combat zone which has been estimated at being 14.7% (lifetime prevalence) and 33% for a reported incidence of one or more symptoms of PTSD at some time since the combat (Centres for Disease Control: Vietnam Experience Study, 1988). However, as with the women in Kessler et al.'s study, being a victim of crime also generated high rates of PTSD, with the highest being neglect (23.9%), physical abuse (22.3%), and molestation (12.2%).

In this same study, Kessler et al. (1995) found that the median time to remission of the disorder was 36 months for those "who ever sought professional treatment" (p. 1056) compared to 64 months for those who did not. However, of even more significance to the current debate was the finding that a sub-sample of more than 33% of people with PTSD failed to remit, even after many years, whether they received treatment or not. This raises the question as to whether treatment is advisable or effective.

Treatment Efficacy. CBT treatments of post traumatic stress disorder have again been shown to be the most effective treatments for traumatised individuals. This has been demonstrated with cases of sexual abuse and family victims of homicide (Deville, 2001), accidents and disasters (Deville and Spence, 1999), sexual and non-sexual assault (Foa et al., 1991, 1999), as well as general victims of crime which meet the criteria for PTSD (e.g. Marks et al., 1998; Tarrier et al.,

1999). Current exposure based treatment protocols show that between 60 to 90% of those treated no longer meet the criteria for PTSD by the end of treatment (Deville and Spence, 1999), an outcome that has now been established through replication in different countries (e.g. Foa et al., 1991; 1999; Marks et al., 1998).

As with ASD, supportive counselling has also been shown to be an ineffective treatment in the amelioration of PTSD in cases of rape, sexual assault and molestation (Foa et al., 1991; Foa et al., 1999), and general victims of crime (Marks et al., 1998). Supportive counselling is, however, usually well tolerated. It is suggested that supportive counselling techniques may be more of benefit to those without pathological conditions following trauma yet with personal problems who require short-term support. However, in agreement with Fattah, and as implied by Gist and Lubin (1999), a chat with “Grandma” may serve the same function as supportive techniques provided by quasi-professionals, without the symptom priming inherent in what these authors see as “socially constructed nosologies” (p. 15). To date there is no research that has looked at either the efficacy or effectiveness of supportive counselling for victims of crime who do not meet criteria for a DSM-IV diagnosis and are sub-clinically distressed.

‘No treatment’ conditions in outcome studies of PTSD have shown time again that there is very little improvement (if any at all) overall, to the point where some researchers are beginning to question the ethics of not providing treatment as part of a clinically controlled study (e.g. Devilly and Spence, 1999).

Dismantling studies comparing the relative efficacy of the various elements of CBT have begun only recently and a clear picture of the conclusions is yet to be painted. Comparisons between exposure and cognitive therapy paradigms have thus far found little difference between the

approaches (Marks et al., 1998; Tarrrier et al., 1999). However, the methodological rigour of studies which investigated the relative efficacy of exposure treatments and cognitive components have been variable, as has been the practical applications of the various techniques (Deville and Foa, 2001). Therefore, it would be unwise at this stage to make any definitive statements with regard to the relative efficacy of one of these treatments over the other. However, one can comment that exposure based treatments currently have more support through the number of studies which have found them to be effective with different traumatised populations and due to the fact that there is no evidence regarding the effectiveness of cognitive therapy in ameliorating PTSD without any form of behavioural activation included within the treatment. Jacobson et al. (1996) found that there appeared to be no additional benefit in treating depression with a full cognitive therapy package, over and above the use of the one treatment element of behavioural activation (a process of gradually increasing desired, healthy activities). Indeed, Golan (2001) found that depressed participants who were treated in one study were more likely to relapse if they were engaged in low levels of behavioural activation at the termination of therapy.

However, the majority of both cognitive and behavioural practitioners currently view the change in personal meaning of events as the main vehicle with which to drive gains in treatment. This theoretical underpinning of treatment effectiveness is an important facet to service delivery, yet is outside the realm of this article to address in any depth and readers are referred to the key articles which discuss this issue and the related issue of physiological engagement during exposure (Davey, 1993; Foa and Kozak, 1986; Rachman, 1980).

So in response to the question of whether these reactions are normal one has to conclude that such reactions and the long term maintenance of these symptoms is not a normally expected

(i.e. average) outcome to nearly all traumatic events. With regard to the question of whether they remit with time and support, again the answer has to be very slowly, if at all; And, most importantly, are we pathologising when we 'treat' people distressed by such symptoms and possibly making them worse, as Fattah suggests? The answer to this appears to be a resounding no, backed by solid empirical research.

However, Fattah is also concerned about the influences of suggestion in cases such as recovered memories of childhood sexual abuse. Indeed this very field of research is topical with those investigating what is now known as Dissociative Identity Disorder (formerly Multiple Personality Disorder).

#### Recovered Memories, Suggestion and Iatrogenesis.

Iatrogenesis is the process whereby a clinician unwittingly evokes reactions and symptoms, and possibly even disorders, in a patient. If during or following the course of therapy a patient demonstrates enduring symptoms that were not present previous to the therapy, the symptoms can be said to be iatrogenic in nature. For example, excessive medical testing is said to be one of the most common sources of over-diagnosis (Ziskin and Faust, 1988). It is argued that the process of iatrogenesis is facilitated in therapeutic situations by having clients who are more open to suggestion (Merkelbach, Devilly, and Rassin, in press). Suggestion refers to a specific influential message being passed on to and accepted by a client. For example, a debriefer informing an emergency worker which symptoms he may (or even worse 'is likely to') experience following his involvement in a traumatic situation. Suggestion is not limited to clinical situations, but might be linked to any behaviour, cognitions or emotions that we have as human beings (Schumaker, 1991). Suggestibility, then, refers to how prone an individual is to respond to messages in the way that is expected of him

or her.

These cases of recovered memories of childhood sexual abuse which Fattah raises is indeed a concern but is a very complex area of research relating to iatrogenesis, suggestion and psychopathology. To thoroughly investigate this aspect would produce a book in its own right and readers are directed to Merckelbach, Devilly and Rassin (in press) for a fuller overview of some of the issues surrounding this topic. However, in precis - there is a split of opinion regarding this topic. Some advocates argue that traumatic memories can become dissociated from consciousness, yet explain a persons current life difficulties. These advocates contend that such memories need to be recovered in order to treat the person (e.g. Brown, Schefflin, and Hammond, 1998) and in some quarters, there has been a tendency to assume these memories are highly accurate (e.g. Elin, 1995).

However, dissenters of this view have doubts regarding the veracity of many recovered memories (e.g. Loftus, 1993) and base these concerns on solid empirical research. For example, Garven, Wood, Malpass and Shaw (1998) investigated iatrogenesis and suggestion in school children in relation to the highly publicised “daycare ritual abuse cases”. These authors found that the interviewing techniques used during the cases at the McMartin School contained at least six serious leading and reinforcing strategies and that when the investigators used these strategies 58% of a classroom made false accusations regarding a classroom visitor compared to only 17% of a group who were questioned with simply ‘suggestive’ questions.

In essence, six interviewing techniques which were identified through viewing the tapes of the original McMartin interviews and should be avoided during assessment of suggestible populations include: Providing negative consequences for ‘denial of problem’, such as criticising an answer; Repetitive questioning although a ‘non preferred’ answer has already been given; Inviting

speculation on what “might” have occurred if it happened; suggestive questions introducing new material into the interview, e.g. “When your dad put you to bed at night, .....”; Conformity pressure by claiming that “others” or co-witnesses have already told you similar stories and hence normalising an ‘expected or desired’ answer; And providing positive consequences such as praising a ‘preferred answer’ or providing ‘special’ treatment for this ‘special’ population..

The above study was followed by Garven, Wood and Malpass (2000) who found that even when only two elements of the ‘McMartin’ interviewing techniques were utilised (reinforcement and co-witness information) more children made false allegations about a classroom visitor compared to children who were asked questions that were only suggestive in nature. However, the largest difference between the two groups was on highly implausible and fantastic false accusations (such as the visitor taking the child flying in a helicopter - which never happened) where 52% of those with the McMartin interview agreed compared to only 5% agreement made by the controls. Of even more importance here, though, is that even once the interviewing techniques of reinforcement and co-witness testimony had been discontinued the children repeated the allegations and, when challenged, the children insisted that their reports were based on their personal observations. Garven et al. (2000) also found that reinforcement had a greater effect than providing co-witness enticements to agree with accusations. These authors (p.45) noted that positive reinforcement in eye witness testimony cases can alter “confidence of adult eyewitnesses in false identifications and change their retrospective reports in forensically important ways”.

We also know that women who claim to have recovered memories of sexual abuse tend to have higher rates of fantasy-proneness, be more amenable to suggestibility, are more likely to display false memory effects in the laboratory and are the most distressed group on measures of

personality and symptom endorsement compared to women who always remembered their abuse and women without histories of abuse (Clancy, Schacter, McNally, and Pitman, 2000; McNally, Clancy and Schacter, in press; McNally, Clancy, Schacter, and Pitman, in press). In fact, this line of argument suggests that these people (women in most cases) make an “effort after meaning” to explain their problems, a process that may also be engaged in by poorly trained or unaware therapists.

So, whilst Fattah is indeed right to be cautious regarding recovered memories one can see from the above explanation that, whilst tangentially related, this is quite a different debate to the utility of treatment for victims of crime with a diagnoses of ASD or PTSD.

### Summary

So where does this leave us? It is concluded that Fattah was quite right to be cautious regarding the utility of psychological debriefing and recovered memory therapy. Individual debriefing, as currently practised, appears to be at best inert and at worst noxious. Recovered memory therapy, likewise, appears to run iatrogenic risks with a very vulnerable population. It is also concluded that policy should be based upon sound empirical evidence and that one should have an understanding of how “the consequences of the victimizing event will be extremely different from one victim group to another, and from one individual victim to the other” (Fattah, 1999; p. 193). It would also appear that good treatment may frequently encompass “reinforcing the natural healing powers of the human psyche, strengthening the family and social networks of potential and actual victims” (Fattah, 2000; p. 42). However, it is not agreed that noting when a problem becomes socially or vocationally dysfunctional that the provision of treatment is a process of pathologising normal reactions. In fact, treatment is imperative when reactions to crime are pathological, and

specific treatments should be aimed at distinct clinical disorders (Bisson and Shepherd, 1995). It is suggested that emergency service workers and those who frequently come into contact with people directly after a distressing event may be best armed with information, particularly of referrals to appropriate people when these are requested, rather than psychological debriefing skills. However, in the very early stages following trauma, particularly one which affects a whole community, the provision of practical information and reinforcing community structures which people usually utilise during times of grief appear, as suggested by Fattah, the best interventions.

As supportive counselling has been demonstrated time and again to be ineffective with a clinical presentation, it is suggested that in order to accomplish a satisfactory outcome specialists with clinical assessment skills need to be utilised in the provision of these services. Failure to heed this proposition could lead to the worsening of symptoms in some individuals (see Tarrier et al., 1999; and Devilly and Foa, 2001; for a discussion related this topic).

Supportive counselling for those who do not develop a clinical condition, but rather present with non-pathological personal problems following victimisation and request assistance, obtains high ratings of client satisfaction yet has still to be demonstrated to be of benefit in relation to either interpersonal or occupational functioning. However, research into this area has recently begun and it is hoped that we will have some answers to this by the year 2003. Further research is also needed to evaluate the effectiveness of self-help groups and victim assistance organisations who provide quasi-professional services by volunteers. This may be just another form of 'tea and sympathy with Aunt Adie', yet it may have iatrogenic elements similar to psychological debriefing - promoting and maintaining 'victimhood' identification and status.

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