Victim Support Service

[Back] [Up] [Next]

A Brief Introduction To The Need for An Incident Recovery

Model Within Victim Services.

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The sequellae to crime can be many and varied for the victim. This can range from physical injury, property loss and occupational disruption to grief, depression, anxiety and mental health issues generally. The purpose of this article is to propose an academic and clinical intervention strategy which aims to address the mental health issues of victims of crime.

Whv Provide Mental Health Services To Victims Of Crime?

Firstly, it is important to understand the necessity for any type of intervention. This is a complex issue

and lies within two domains. On one hand there is the monetary compensation versus practical and psychological assistance debate, and secondly there is the issue of looking at whether victims of crime require the availability of psychological help. This paper will deal with only the second issue.

The type of crime committed and the demographic grouping of the victim often reflect different psycho-social outcomes. Child abuse, for example, can lead to a host of internalising or externalising problems that can become pathological in nature, such as post traumatic stress disorder (PTSD), generalised anxiety, depressive disorders, oppositional / defiancy, conduct disorder and the later development of paraphilic behaviour, to name just a few. Rape can lead to specific anxiety disorders (such as obsessive compulsive disorder, post traumatic stress disorder, specific phobias, etc), depression and even a brief reactive psychosis. One study (Lopez, Piffaut, and Seguin, 1992) showed that 71% of raped women suffered from major depression and 37.5% developed chronic PTSD that lasted from 1-3yrs. No matter which demographic group and crime-type victim, there are always special requirements that need to be borne in mind.

For example, the female rape victim may need rape specific information (e.g. epidemiological statistics) that she can integrate into her experience and allay any misplaced feelings of guilt that may have occurred following the attack. Therapists and researchers also need to be aware of the literature relating to female rape and predictors of outcome (e.g. perceived controllability over aversive events generally relate to symptom severity, yet the association between controllability and PTSD is neither mediated nor moderated by assault severity measures, Kushner, Riggs, Foa, and Miller, 1993; prolonged imaginal exposure leads to better long term outcomes than just stress inoculation training with rape victims, Foa, Rothbaum, Riggs, and Murdoch, 1991; and specifically when conducted appropriately by well trained clinicians, Devilly and Foa, in press). The male rape victim, on the other hand, may need to look at issues relating to sense of self from a slightly different angle and interpreting the event within a society which the victim may have believed predominantly rewards the strong and ignores the weak.

As one can see the myriad possibilities of an interaction between crime type and demographic grouping leads to many possibilities of mental health outcome, the special needs that are required by the victim, and the literature that should be understood by the therapist or researcher. For the purpose of this article, and due the frequent nature of this specific outcome due to crime, the example of PTSD has been taken to look at the epidemiology within the community at large.

The PTSD Example.

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 rape as 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%).

As with much research into the epidemiology of pathological conditions the results, such as those above, have been conflicting due to the method of obtaining the data, the measures employed, classification cut-offs and samples surveyed. For example, Resnick, Kilpatrick, Dansky, Saunders and Best (1993) found that in a telephone survey of women, 12.3% of respondents had a DSM-III-R lifetime prevalence rate of PTSD (as opposed to Kessler et al's 10.4%). Resnick et al. contribute this higher rate to the anonymity of using a telephone to procure the data. Likewise, O'Toole et al. (1996) looked at 1000 randomly selected Australian Vietnam veterans and found the lifetime prevalence rate of PTSD to be 20.9% (SCID-PTSD scale) with 11.6% of the sample experiencing current PTSD symptoms. The use of different measures, sampling methods and geographically located groups can be seen, therefore, to influence epidemiological findings and limit their specific interpretation, although allowing for generalisations.

Lifetime co-morbidity rates with PTSD are also high for both men (88.3%) and women (79%), with PTSD, on the whole, being primary with respect to affective disorders and substance use disorders. However, of particular importance to victim services is the persistence of PTSD once having met the criteria. While the median time in Kessler's study to remission was 36 months for those who sought treatment and 64 months for those who didn't, an important fmding in it's own right, it is noteworthy that over a third of those with PTSD remained meeting criteria for many years without remission whether they sought treatment or not.

To put this into some perspective and to provide the reader with an idea of how many people could be affected by PTSD alone within Australia, the Australia Bureau of Statistics concluded that:

"An estimated 79,100 persons aged 15 years and over were victims of robbery and 618,300 persons aged 15 years and over who were victims of assault in the 12 months prior to the survey. An estimated 30,100 females aged 18 years and over were victims of sexual assault in the same time period." (Australian Bureau of Statistics, 1998)

Of course this only includes robbery, assault and sexual assault and does not include the vast array of offences which can threaten the physical or personal integrity of the victim. Treatment Delivery

With such large numbers being affected by crime and the survival curve of pathological responses, treatment efficacy and methods of delivery are therefore of critical importance to the community at large and victims organisations specifically. Through the use of clinically controlled studies active therapeutic components are being identified and treatment methods are being streamlined and disseminated. Continuing with the example of PTSD, until the late 80's it was predominantly believed that PTSD was generally resistant to therapeutic intervention and victims of crime with this disorder were prescribed long-term psychoanalytic therapy, individuals often being seen over many years two or three times a week. However, with the integration of the scientific method into clinical psychology and psychiatry came controlled clinical trials which have shaped our theoretical perspectives and the delivery of treatment under a best practice model. In the case of PTSD the initial trials utilised mainly Vietnam veterans, but over time this switched to rape victims and then victims of crime in general. It has reached a point now where 80 to 90% of all PTSD cases will be successfully treated in 8 to 12 sessions (Devilly and Spence, 1999; Foa et al., 1999).

For example, Keane, Fairbank, Caddell and Zimmering (1989), conducted a randomised clinical trial of implosive (flooding) therapy with 24 Vietnam veterans diagnosed with PTSD. These participants either received 14-16 sessions of implosive therapy, including relaxation training, or were assigned to a wait-list control. When compared with the controls, at post-treatment and 6 month follow-up, the experimental condition evidenced significant improvement, across a range of standardised measures, in the symptom clusters of re- experiencing the event and anxiety and depression. However, the numbing and social avoidance aspects of PTSD did not show improvement. Cooper and Clum (1989) also compared imaginal flooding to milieu treatment in combat-related PTSD patients and, whilst finding flooding to be effective for PTSD symptomatology, showed it to be ineffective in changing depression and trait anxiety with this population. This increased effectiveness of direct exposure over milieu treatment as part of an inpatient PTSD programme for Vietnam veterans was similarly demonstrated by Boudewyns, Hyer, Woods, Harrison and McCranie (1990). Such approaches to combat-related PTSD (utilising exposure based therapies) within an inpatient PTSD programme have also been reported as effective in other, similar research reports (e.g. Frueh, Turner, Beidel, Mirabella and Jones, 1996).

Of direct importance to victims of crime and the provision of victim services for this diagnostic grouping was the aforementioned turn toward investigating treatment efficacy with rape victims and eventually

generic PTSD cases. For example, Foa et al. (1991) compared a wait-list control (WL) with three treatment regimens; stress inoculation training (SIT), supportive counselling (SC) and prolonged exposure (PE). All 45 participants were female rape victims with a PTSD diagnosis. Each participant received 9 bi-weekly treatment sessions of 90 minutes duration. A summary of the results revealed that all treatment conditions displayed significant improvement at post-treatment and follow-up ($p<.001$). However, SIT displayed significantly greater improvement on PTSD symptomatology immediately following treatment than PE, SC and WL. At follow-up (3 month) PE displayed significantly greater improvement on PTSD symptomatology. This improvement was across all 3 symptom clusters, in contradiction to the Keane et al. (1989) study. It is suggested that the inclusion of in vivo exposure, the theorised most active ingredient in the treatment of avoidance symptoms (Marks, 1987), may have increased the treatment efficacy. Foa (1995) rationalised that if participants performed best in the short term with SIT, due to the anxiety management aspects of this treatment, and better in the long term with PE, then a combination of the two treatments may be the most effective.

In order to examine this hypothesis, Foa (1995), and Foa et al. (1999) conducted trials on rape victims, diagnosed with PTSD, with 4 conditions; WL, SIT, PE and PE plus SIT. Again 9 bi-weekly treatment sessions, each of 90 minutes duration, were administered. Contrary to predictions, it was found that whilst participants in all conditions improved, PE alone proved the most beneficial, followed by PE + SIT. In fact, any condition with the PE was superior to any condition without it. This result led Foa (1996, personal communication) to initiate trials of PE and Cognitive Restructuring, as a treatment protocol for PTSD, following the work of Resick and Schnicke (1992), and in line with the cognitive models of PTSD (e.g. Foa and Kozac, 1986). Resick and Schnicke (1992) compared a group based intervention employing a combination of cognitive techniques (i.e. predominantly challenging maladaptive thoughts) and behavioural practices (predominantly exposure) to a wait-list control group for women who had been raped. The CBT condition was devised from an information processing model with the basic tenet that, following rape, many individuals assimilate the event into their current beliefs (e.g. "I must have deserved it because good people aren't raped"), whilst a better outcome is achieved when people accommodate the event by changing their existing schemata (e.g. "Sometimes bad things can happen to good people"). The results showed that the CBT protocol was far superior to the wait-list control at post-treatment and this improvement in symptomatology was maintained to 6 month follow-up. This led the authors to speculate whether the cognitive component or the exposure component would be superior should such a design be implemented in future research.

Therefore, Tarrier, Pilgrim, Sommerfield, Faragher, Reynolds, Graham and Barrowclough (1999) reported on the relative efficacy of cognitive therapy and an exposure method in treating PTSD in participants who were predominantly victims of crime. They found no difference between a cognitive intervention and imaginal exposure at any time point, and due to the difficulties with the method of treatment delivery in this study very little in the way of implied efficacy could be made (Devilly and Foa, In Press). The lack of a statistically significant difference between cognitive interventions and exposure techniques was also found by Marks, Lovell, Noshirvani, Livanou, and Thrasher (1998). However, it should probably also be noted that any condition which contained exposure appeared to display a larger effect size than other interventions by six month follow-up (although this was not statistically significant).

Devilly and Spence (1999) compared Eye Movement Desensitisation and Reprocessing and a CBT variant based on Foa's PE+SIT (Trauma Treatment Protocol, TTP) in the treatment of generic PTSD, via a controlled, clinical study using therapists trained in both procedures. It was found that TTP was both statistically and clinically more effective in reducing pathology related to PTSD and that this superiority was maintained and, in fact, became more evident by three month follow-up.

As can be seen, such research is of vital importance, the results of which eventually translate into recommendation of treatment delivery. The above example of PTSD is just but one of the possible mental health issues of which modern interventionists need to be aware. Such scientific investigations have naturally also been applied to other psychological reactions to crime and best practice models have been suggested. For example, research along the above line has been applied to other disorders, ones that are also common sequella to crime, such as obsessive-compulsive disorder (e.g. Van Oppen, deHaan, Van Balkom, Spinhoven, Hoogduin, and VanDyck, 1995), panic disorder with agoraphobia (e.g. Bouchard, Gauthier, Laberge, French, Pelletier, and Godbout, 1996; Oei, Llamas and Devilly, 1999), depression (e.g. Hollon, DeRubeis, Evans, 1996; Elkin, Gibbons, Shea, Sotsky, et al. 1996), generalised anxiety disorder (e.g. Durham, Murphy, Allan, Richard, et al, 1994; Borkovec, and Costello, 1993; Borkovec, Newman, Pincus, Lytle, and Abel, manuscript in preparation), chronic pain (Kole-Snijders et al., 1999), and drug abuse (Ouimette, Finney, and Moos, 1997; Guydish, Sorensen, Chan, Werdegar, Bostrom, and Acampora, 1999) to name just a few. One can see that, therefore, it is important to be aware of the changing face of treatment recommendation and to be able to critically evaluate all treatment outcome research.

With this in mind the Department of Criminology at the University of Melbourne has initiated a victims services course within the forensic masters and it is hoped that this will eventually develop into it's own masters course. This course has only recently been initiated and it is expected that the course layout will change over time. However, at this time the course falls within two domains within victim services: Incident recover and organisational issues.

Victim Services: Specialitv Training In Incident Recovery.

This course initially aims to educate therapists and organisational workers and advocates for victims of crime about best practice models in a subject which addresses the assessment and treatment of victims of crime. This subject provides a systematic approach to the assessment and treatment of victims of crime and, more specifically, the issues surrounding Post Traumatic Stress Disorder (PTSD). With a scientist-practitioner model of assessment and treatment being advocated, this subject covers normal and pathological reactions to crime, an overview of the psychopathology of anxiety and depressive disorders, possible diagnostic sequella to trauma, the epidemiology of PTSD, theories of aetiology relating to PTSD and depression, the appropriate psychometric assessment of trauma reactions, treatment options, and a critique of more novel therapies. This subject also provides a practical skills training component that is

ideally suited to therapists.

However, as mentioned at the start of this article, the type of crime committed and the demographic grouping of the victim often reflect different psycho-social outcomes. With this in mind a special needs group subject addresses the major interactions between crime type and the demographic grouping of the victim. Delivery of the course will be predominantly broken down into aspects of criminal justice, pragmatic and treatment I intervention issues. As well as inspecting the overall evidence for special needs groups this course covers, amongst other groups, sexual assault and domestic violence, Aboriginal needs, ethnic & culturally diversified groups, victims of homicide, "missing presumed dead", and those requiring acute crisis interventions. This course also evaluates the necessity of providing acute crisis interventions and provides practical demonstrations of intervention delivery methods.

Naturally a placement, or forensic fieldwork practicum, is also offered. Students have the option of undertaking a fieldwork practicum lasting 52 days in their area of interest - which in this case is victim services. The practicum provides students with an opportunity to gain valuable experience in the professional forensic practice of their core discipline. A case conference component provides an opportunity for integration of material learned in other didactic and experiential settings, including (and where applicable, as determined by discipline) diagnosis, assessment, case formulation and treatment. Through this medium students gain valuable experience in presenting completed or on-going cases in a coherent and integrated manner.

Victim Services: Speciality Training In Organisational Issues.

Although education regarding treatment models and techniques is of primary importance, it is only through the existence of advocacy, referral and assistance organisations that those who have been a victim of crime and cannot afford private treatment, will be effectively serviced. Therefore, another aspect of the course on victim services relates to basic organisational issues and also keeping abreast political and research based innovations within the area. The organisational issues subject inspects service models, methods of service delivery, fmancial considerations at an organisational and departmental level, interaction with government and other community services and issues related to service deliverers. This includes methods of assessment related to appropriate therapeutic providers, decision making processes and the evaluation of the providers and the service as a whole.

More specifically the current issues subject addresses the latest trends in victim services, theoretical models in associated areas of psychopathology and local and international organisations. Guest speakers from domain specific backgrounds are strategically integrated into lecture delivery and political, as well as scientific factors, in policy generation and intervention trends are addressed. Further to this subject a course in victimology is also offered which provides an examination of a broad range of criminological and sociological issues in victimology, including concepts of 'victimhood', victimology as a discipline,

trends in victimisation, the role of the Victim Referral and Assistance Service, and victims in the criminal justice system.

Summary.

It is proposed that the provision of assistance within victim services is now at the stage where the ever popular term 'best practice model' is not just a good idea, but rather a reality and an expectation which those who have been victimised are entitled to: the best service at an organisational level, the most appropriate assessment, the most effective treatments which have been validated and delivered by those with contemporary and apropos training.

Just some of the issues relating to the psychological well-being of victims of crime have been presented, with the example of PTSD, and a new course outlining Australia's first victim services course has been proffered.

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[Back] [Up] [Next]