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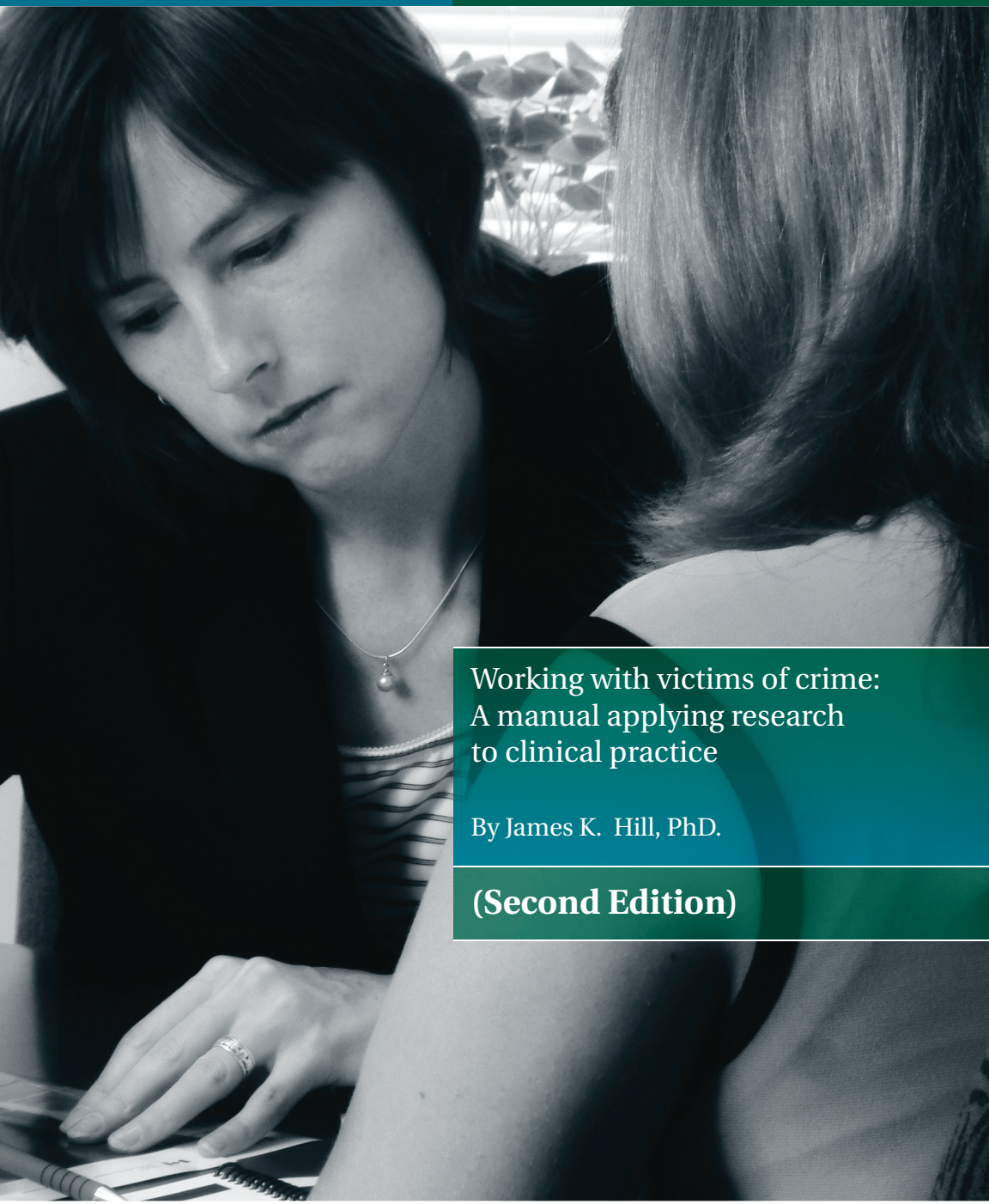

Working with victims of crime: A manual applying research to clinical practice

By James K. Hill, PhD.

(Second Edition)

Department of Justice Canada
Ministère de la Justice Canada
Canada

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Foreword

The challenges that face people working with crime victims can seem daunting. Those who work in this area often show an investment in this population that goes beyond the standard research study. An understanding of psychological changes that relate to being victimized is a key part of understanding the crime victim's internal world. The victim's ability to cope with the crime, crime-related trauma and later decision-making are an important part of even the most basic personal contact. This document is based upon a 2003 Department of Justice Canada publication entitled: *Victims' response to trauma and implications for interventions: A selected review and synthesis of the literature* (Hill 2003). In that document I explored the cognitive change in victims; how victim characteristics, cognitive changes and coping skills impact clinical understanding and interventions. In that document, I intentionally focused on relatively recent research to reflect recent thinking in this area.

This manual is focused on applying these research findings to the daily challenges that face those who work with crime victims, in any capacity. There are several reasons having recent research at one's fingertips can be useful. First, having research support for your work can validate the work that you are doing. Second, front-line workers can learn new approaches and get new ideas from research, improving their effectiveness and services to clients. Third, it is my hope that clinicians, paraprofessionals, volunteers and administrative staff will use this resource as a solid base on which to build an effective service. Finally, they can use this information to educate themselves, victims and the victims' friends, families and other supports about the complex psychological issues facing victims of crime.

The interpretations in this document are solely those of the author and are not necessarily those of the Department of Justice Canada or its employees.

Foreword to the Second Edition

In the Foreword to the original manual, I discussed the challenges that face people who work with victims of crime. This second edition basically follows the structure and approach of the original manual, but incorporates new information, research and advances in the field. The goal was to keep the general structure, length and spirit of the original manual intact while providing new resources that workers might use. This will help us to understand how we can better partner with victims of crime to help them move forward.

Keeping up-to-date with advances is a basic part in developing a professional model of service delivery. We can stay current through consultation, supervision, workshops and self-study. I have intentionally added more references to key points so that readers can use them as a jumping-off point to do further reading in that specific area. I strongly recommend workers use this manual as a beginning of further learning.

The interpretations in this document are solely those of the author and are not necessarily those of the Department of Justice Canada or its employees.

Acknowledgements

The author would like to gratefully acknowledge the help of the readers of the speciality chapters: Dr. Karen Mock and Steve Sullivan. I would also like to thank Dr. Lara Robinson and the staff at the Department of Justice Canada for their helpful comments on earlier drafts of this manual.

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Introduction

This manual is designed mainly for those who deliver front-line services to crime victims. As a quick reference resource, it should help front-line workers provide better services by giving them access to recent research and theory related to crime victims. For the purposes of this manual, "front-line workers" are broadly defined as those who come into contact with victims in any role, from reception staff to clinicians to support workers. Although the focus is on clinical intervention, readers should note that any contact with victims can be healing for them. To this end the term "worker" will be used throughout the manual as a catchall term to mean professionals, paraprofessionals, volunteers, support staff, administrators and anyone who comes into contact with victims with a focus on helping. The manual has two parts: General Issues and Specialty Populations.

Part One: General Issues with working with Victims of Crime

Part One focuses on general research findings that can be linked to skills development. Each section focuses on common experiences of crime victims and other important issues. "The Importance of Self-Care" focuses on advice to workers for taking care of themselves as they work within this challenging and rewarding area. The "Model of Victimization and Recovery" presents a model of how people become victims and psychologically adjust to their victimization. The section entitled "Common Reactions to Crime" reviews the common reactions people can have after criminal victimization, the issue of previous victimization, and the severity of reaction. The next section, "How Do Victims Cope?" focuses on coping strategies often used by victims and strengths victims might use to heal. "A Model for Client Change: The Stages of Change" presents the Transtheoretical Model of Change (Prochaska et al. 1992) and describes how it might be used to help victims to increase their motivation in getting help. "Assessment Issues: What should I ask about?" focuses on possible areas workers might want to explore in meeting with victims. Finally, "Pulling it Together: Concluding Remarks" summarizes the key findings, and can be used as a quick resource to remind readers of the research in this area. The end of each section also has a quick-reference page called "The Basics," which summarizes the key points of the section. Each section in the manual covers issues related to victims, but also provides suggestions for how workers can improve their skills and abilities.

Those familiar with the original version of this manual will notice changes in the above sections. For the most part, new research has been added to each section. All new articles in the reference sections have an asterisk in front of them. This will give readers an idea of the scope of this update. The following are some of the key updates:

- "The Importance of Self-Care" includes more self-care information and strategies.
- "Model of Victimization and Recovery" includes more information about why victims report crimes.
- "Common Reactions to Crime" has more information on grief and complicated grief
- "How Do Victims Cope?" now has new items under both positive and negative coping strategies. There is also a major revision and expansion that discusses resiliency, self-efficacy, and post-traumatic growth.
- "Assessment Issues: What should I ask about?" now has a section that focuses on identifying client strengths and resources.

Part Two: Specialty Populations

Part Two of the manual contains two new chapters on special subgroups of victims: Victims of Hate Crimes and Victims of Terrorism. These chapters are written to be a review of the issues that you might encounter if you are working with these subgroups of victims. Although these chapters are introductions, they include detailed information. The hope is that workers who have clients facing these challenges will be able to improve their understanding of the complex issues involved and, again, improve the effectiveness of their work.

Another difference about these additional chapters was the writing process itself, which drew on special topic readers to provide guidance. Each reader was asked to provide key articles and research in the area and offer feedback on early drafts of the chapter. The goal of this process was to ensure that the information was not simply based on recent research and theory, but also would be useful to those working with these special groups. To ensure fairness, I set up a process to deal with any disagreements. In case of a disagreement, the reader's position would be included in the chapter (along with my view), clearly identifying it as his or her position. I am pleased to report that there were no disagreements and that the chapters reflect my perspective, informed by the helpful comments of each reader.

The readers provided the following short biographies:

Working with victims of hate crimes: Reader: Karen Mock[1]
Dr. Karen Mock, a registered psychologist, educator, trainer and consultant for over 30 years, is former Executive Director of the Canadian Race Relations Foundation and of the League for Human Rights of B'nai Brith Canada. She has been qualified by the courts and human rights tribunals as an expert in human rights, racism, discrimination, anti-Semitism, and hate group activity, and chaired the Hate Crimes Community Working Group throughout 2006 for the Government of Ontario. Dr. Mock is widely published and has received several awards and honours for her work.

Working with victims of terrorism: Reader: Steve Sullivan
Steve Sullivan, a long-time advocate for victims of crime, was named by Order in Council the first Federal Ombudsman for Victims of Crime in April 2007. He began working in the victims' rights movement in 1993, and has advocated for more victim rights and victim services. He has appeared before numerous federal committees on various issues, including victim rights and better protection for victims of child sexual exploitation, and is promoting the need for services for victims of terrorism.

Throughout this manual, a crime victim will usually be defined as a person who has directly experienced and suffered because of a specific illegal act. These people are the main focus of the research reviewed for this manual. However, workers must remember that crime affects everyone. For example, front-line staff recognize that crime often injures the victim's loved ones and support people. These people may also suffer psychologically, socially or financially, and may have to deal with many of the same issues as the victim. The chapters on victims of hate crimes and terrorism discuss this issue in more detail. The clinical skills and information provided in the manual may be of help to these potential supports as well.

1 Dr. Mock provided research articles and reviewed the earlier draft of the chapter, but scheduling conflicts and administrative issues prevented her comments from being received in time for the final revision.

Part One: Working with Victims of Crime

1.0 The Importance of Self-Care

1.1 Why is Self-Care so Important?

> A farmer was using a well-used, dull, rusted axe to cut a huge oak tree on his property. His neighbour was passing by and saw that the farmer was making no progress at all.
> "At this rate," the neighbour thought to himself, "it will take him years to chop that gigantic tree down."
> So he said to his friend, "Why don't you sharpen your axe?"
> The farmer replied, breathless: "I can't (chop)…take the time (chop)…Must cut down (chop)…this tree (chop)…by tomorrow."
>
> Based on a Sufi teaching tale

Like the farmer chopping down the tree, we, as victim service workers, can get caught up in trying to reach our goals. We do not think about how we are doing our work or how we can do it better, because we are so busy. As workers we want to help; this is the reason we do this work. However, we can lose sight of our own needs because of all the work we see around us. We say, "What are my problems/ stress/ exhaustion in comparison to what this person is dealing with!?!" This single-minded focus is also quite seductive, because others working with victims will support these "selfless" and "self-sacrificing" acts as dedication and empathy. I disagree with this view. As we stop taking care of ourselves, we wear down the major tool of our work. Like the farmer chopping the oak with a dull axe, there is activity – but how useful is it? We also need to have empathy for ourselves, as the tool with which we work. The bottom line is that if we are trying to help clients build skills, then we need to take care of ourselves. We need to act as models of self-care. For this reason, the manual begins with a discussion on the importance of workers looking after themselves.

It goes without saying that working with victims can be stressful, but some researchers have looked at this issue more closely. Brown and O'Brien (1998) found that 65% of workers in battered women's shelters are moderately to highly stressed due to anger and frustration related to the behaviour of both victims and perpetrators. Added challenges of the job include stress related to time pressures, red tape, physical demands and lack of general achievement in their job (Brown and

O'Brien 1998). Thus, these researchers found that job stress is related not only to the clients but also to dealing with the system. This is likely not very surprising to workers. However, it is important to emphasize this point to administrators and supervisors, who should monitor themselves and their staff for signs of burnout and job stress.

In a study looking at different types of clinicians, Holmqvist and Andersen (2003) interviewed experienced therapists who worked on a special project with victims of war-related trauma. They compared this group with therapists from general therapy settings and group homes. They found that the therapists who worked with trauma victims reported being less objective and less "motherly," and feeling less enthusiastic than those working in general therapy. In comparison to those working in group homes, trauma therapists reported being more anxious and embarrassed. Further, as these therapists worked with trauma victims they became more detached and more bored, and reported less anxiety and reservation (Holmqvist and Andersen 2003). Perhaps as the therapists become more detached they are better able to deal with the anxiety related to their work. However, this does not serve our clients: Holmqvist and Andersen (2003) emphasized the importance of therapist self-care, and noted the danger that distancing could interfere with good clinical work. Cloitre et al. (2007) found that child abuse survivors in treatment for post-traumatic stress disorder did better in treatment if they had a positive relationship with the therapist. Workers must engage in self-care to be able to build strong, professional relationships with the victims with whom they work.

Self-care is important; our self-care activities, however, can have positive or negative effects depending on what activities we choose. Passive methods such as avoidance, ignoring the source of stress, or using alcohol or drugs are not the best ways of dealing with the stress, because they do nothing to address the underlying problem (Pines and Aronson 1988). If the problem is left unchecked, stressed-out workers can end up quitting, becoming ill, or basically just becoming less and less effective in their daily work. Thus, it makes sense to move towards more active ways of coping such as talking about our sources of stress, getting involved with other activities, or changing the source of our stress (Pines and Aronson 1988). These researchers also found that workers who have a positive attitude show less career burnout as well.

1.2 Self-Care Activities

Each worker is different. We each need to identify what healthy self-care behaviours will help us reduce stress and fatigue. This will help us both in our work with victims and in our ability to build a balanced life. The following are possible ways in which workers can seek balance. Doing so may also help ensure that we increase our success with clients and still meet our personal needs in the rest of our lives.

Self-Assessment

To understand our stress levels, we should continually assess and examine our feelings, thoughts, and behaviour (Grosch and Olsen 1994). We need to understand the difference between normal fatigue and the exhaustion that is related to burnout. This is different for each person. Often, burnout fatigue appears as not feeling rested after sleep, losing energy quickly, feeling frustrated, or feeling empty and "wrung-out" (Grosch and Olsen 1994; Pines and Aronson 1988). Needless to say, these feelings can also result from physical illness, so consulting a doctor is important if one suspects a medical problem. However, consulting with peers and supervisors can also help us to understand where we are and how we can cope better. As workers we need to listen closely to our bodies, feelings and thoughts, but also to feedback from others. Listening to co-workers, friends and family can be a good way to keep track of stress levels. Thus, advice and insight from any source needs to be examined to decide what works for each of us. Interested workers are referred to Richardson (2001)[2], who included a self-awareness exercise in the appendix of her publication on vicarious trauma.

Use of effective supervision/ peer support

As mentioned in the Self-Assessment section, workers must rely on others to give them feedback on their stress level (Gorman 2001; Grosch and Olsen 1994; Kottler 1999). Researchers have found that workers who feel supported by their supervisors, friends and family showed less emotional exhaustion and felt more connected to other people and their own feelings (Brown and O'Brien 1998). Other researchers see supervision and consultation as one of the most important factors in preventing burnout (Salston and Figley 2003).

2 See the "Further Reading" section for this chapter.

In consultation and supervision we also need to take time to focus on our successes and the positives of our work – no one wants meetings that focus solely on what has gone wrong.

As workers, we need to build a network that helps support us and from which we can receive clear, direct feedback. Building a network of support that tiptoes around us, or treats us like delicate glass figurines, will not help if we need clear feedback. Remember: this may include feedback from friends and family, because they may notice small changes that could grow into big problems. They also can help support us in making sure that we do not focus only on our work (Kottler 1999). In building this system, we could include "burnout checks," checking on stress and exhaustion levels, as part of normal supervision or team discussions.

Setting boundaries

Workers need to learn to set clear boundaries (Grosch and Olsen 1994; Kottler 1999). Anyone working in a helping profession knows this pearl of wisdom, but many ignore these boundaries when overworked or stressed. Boundaries are basically the limits that we set on ourselves to ensure quality care. Daniels, Bradley and Hays (2007) note that workers might choose to limit caseloads, which may mean limiting numbers but should also mean balancing our caseloads among teammates so that no one worker is dealing with all the challenging cases.

Remember – setting strong boundaries does not mean that we cannot be adaptable. Workers simply need to be aware of boundaries and how to apply them in a way that benefits both themselves and their clients. One worker might decide that she never works past 6 pm, another doesn't give out his home number, and a third will not talk to her clients about her personal life. Team discussions and supervision meetings are excellent times to explore boundaries. Different people and different professions draw boundary lines differently – the key question to ask is: "Do my boundaries help me build and keep resources for the benefit of myself and my clients?" By always putting our needs last, we risk becoming less effective as a worker and as a person.

Building a balanced life

Another important issue in self-care is balancing home and work life: We do not exist only at work. We can have stress in our home life. Money worries, relationship problems, medical stresses do not disappear just because we walk through our office door. Remember – stress at home can affect work just as easily as stress from work can affect home. The activities and skills described below can help us deal with stress in all parts of our lives, not just the challenges of work.

Balancing your life includes setting limits (Grosch and Olsen 1994); boundaries are often one of the first things we give up as we start to ignore our needs. Thus, working over a couple of lunches because that's when the client can meet us is seen as no big deal. Certain offices and supervisors may even see this as dedication. However, this behaviour is the first step to ignoring our own needs and, potentially, to burnout. There is a fine line between being the "hero" of the clinic and needing to go on stress leave!

Workers who become overly focused on work run the risk of meeting personal needs through providing help to clients (Kottler 1999). These personal needs may be to feel useful, have social contact, be valued, or address unresolved childhood or relationship issues. It is great to feel a sense of accomplishment in our work and even to grow because of what we do (Hernandez et al. 2007), but meeting our needs in our job does not necessarily mean we are meeting our client's needs. If, on the other hand, we are meeting our needs in other areas (e.g. through home life, friendships, spirituality) then we may be less likely to try to seek this at work.

What does a balanced life look like?

We each find balance in different ways. Basically, we need to look at the different roles we play in life: spouse, worker, friend, parent, child, and so on. Which are the most important? Each worker should arrange his or her roles in order of importance and set aside time for the most important. Where do we recharge our batteries? For example, if self-care is important, we will set aside time in our week for activities that we view as soothing. These might include meeting friends for coffee, reading a "fun" book (not a work-related manual like this!), playing softball, meditating, golfing, or painting. It can be useful to write out a "Recharge List" of things that help you rebuild or unwind, and keep

it handy so that when you feel tense or overwhelmed, you can quickly look at the list and do something on it that will help you take a breather. Bryant and Veroff (2007) describe this process as going on a formal "Daily Vacation" where you take 20 minutes to enjoy a pleasant, relaxing activity. During the activity you set aside all distractions and worries, paying attention to fully experiencing your enjoyment (including your thoughts and feelings) and ending the vacation by planning what you will do in tomorrow's vacation. At the end of the week, you review all your daily vacations and notice how your week went – especially in contrast to weeks when you did not take daily vacations.

The key to understanding a balanced life is to realize that we each have limited resources that need to be rebuilt; we cannot do it all. Stress in any part of your life will affect your resources in other areas – stress at work affects your home life, financial stress affects your work and relationships. This is normal. Balancing your life is basically a process of deciding how many resources you have and then using those resources in areas that are important to you. Through planning ahead, you are more likely to feel in control and less likely to feel that stress runs your life. Remember – these activities will likely improve your overall quality of life, not just your work.

Education and professional development

Workers can always benefit from professional development and training. Salston and Figley (2003) see training in dealing with trauma as important to reducing burnout. These activities not only teach new skills, but also give time for workers to reflect on their performance. In other words, development sharpens our skills (like the axe) by taking time to review our approach (noticing the dullness) and adding or improving our skills (sharpening). Although developing skills around self-care and setting boundaries is important, the benefits associated with learning any new skill or looking at an issue from a new vantage point can help you recharge in providing services. In a sense, setting aside time to read this manual is self-care.

Services for workers

Workers also need to know when to seek out help. Possible treatment options include self-help (e.g. reading self-care books), support groups, psychotherapy, and outpatient or inpatient treatment (Grosch and Olsen 1994; Kottler 1999; Salston and Figley 2003). Basically, these direct methods of dealing with stress help us take care of our needs. This is the farmer taking the time to sharpen his axe. The choices we make depend on our goals. For example, if it is important to deal with past issues at a deep level, therapy may be the best approach. However, if we just need a place to unload our stress, a self-help group may be in order. Self-help resources are a great way to identify new ways to deal with stress around work and home. It all depends on our stressors and goals. We may also find that we use a mix of methods, using different approaches at different times. We are the best judge of what works for us, but we can all benefit from getting help and feedback from others.

Conclusion

It may seem odd to begin a manual on the psychological effects of crime victimization with a discussion on workers. This approach is taken for one key reason: working with people in distress is a highly stressful and highly rewarding activity (Grosch and Olsen 1994; Pines and Aronson 1988). Workers should not ignore the rewards of this work, but these benefits can only be felt if we feel healthy (Kottler 1999). In recognition of the rewards, researchers have recently started to investigate a phenomenon called vicarious resilience, which focuses on how those working with victims can learn and benefit from witnessing client growth and resilience (Hernandez et al. 2007). These researchers interviewed psychologists who work with victims of social violence, political violence and kidnapping. They found that the therapists were able to identify important benefits of this work, including increased hope for growth, belief in people's strengths, improved clinical skills, social empowerment, appreciating blessings and enhanced meaning (Hernandez et al. 2007). It is good to be reminded of these benefits.

Workers best serve themselves and their clients by watching their stress and actively pursuing activities that build personal resources. There can sometimes be an expectation – on our part or as part of the culture in the helping agency – that we can handle everything. Such views are

tempting because the work is very important. Some view working with victims as a "calling" wherein we silently shoulder the stress, but this misses the point. Working with crime victims is difficult; it is normal that we will sometimes feel drained. Working with victims is rewarding: it is normal that we will feel moved and inspired. As workers we must remember that we need to take care of ourselves first, before we can take care of others. If we ignore our own care we are like the farmer chopping the tree with a dull axe – we're busy but we're not getting anywhere.

1.3 Further Reading on Self-Care[3]

Self-care activities are important. This is a manual on crime victims, not workers, and so self-care activities are only briefly introduced in this section. Interested readers are directed to the following resources and Web sites to increase their knowledge in working with victims and self-care. Good self-care should help us to improve our job satisfaction and effectiveness in our work and daily life. Of particular note is:

> Richardson, J. I. 2001. *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers*. Ottawa: Health Canada.
> Web link: http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/trauma_e.pdf

The following resources can also be found on the Internet:

> The International Society for Traumatic Stress Studies: Good links and resources: www.istss.org
>
> Hope Morrow's Trauma Central: Several articles on vicarious traumatization and burnout:
> http://home.earthlink.net/~hopefull/
>
> Dr. Laurie Anne Perlman's selected bibliography on the Web at:
> www.isu.edu/~bhstamm/ts/vt.htm
>
> The U.S. National Center for Post-Traumatic Stress Disorder:
> www.ncptsd.org

3 Please note: The links provided in this manual were active at the time of publication, but organizations commonly restructure Web sites and move material. If the link does not work you can search the organization's site or use a general search engine to find the document or resource.

Ontario Council of Agencies Serving Immigrants at Settlement.org:
http://atwork.settlement.org/ATWORK/SC/home.asp

National Family Violence Clearinghouse, Public Health Agency of Canada:
http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/index.html

Self-care Guide from the Public Health Agency of Canada
http://www.phac-aspc.gc.ca/publicat/oes-bsu-02/caregvr-eng.php

1.4 The Basics

- Self-care is key to better service delivery.
- Workers need to take care of themselves first, if they are to effectively help their clients.
- Workers can be models of good self-care.
- Workers can choose to apply effective coping strategies (dealing directly with the problem) rather than poor coping strategies (avoidance, ignoring, "working through the stress").
- Self-care behaviours can include:

  - ➢ Self-Assessment – watch for signs of stress (numbness, feeling or being disengaged, unmanageable emotions) and strength (resiliency, supports, spirituality) (Grosch and Olsen 1994; Kottler 1999; Maslach and Leiter, 1997; Pearlman, 1999);
  - ➢ using effective supervision from superiors and peer support from coworkers (Grosch and Olsen 1994; Kottler 1999);
  - ➢ focusing on the things that went well and areas of potential growth and development;
  - ➢ setting boundaries, both in your work and home life (Balanced life) (Grosch and Olsen 1994; Weiss, 2004);
  - ➢ taking a Daily Vacation (Bryant and Veroff 2007);
  - ➢ building a balanced life (Grosch and Olsen 1994);
  - ➢ using support groups, therapy, outpatient treatment, etc.; (Grosch and Olsen 1994);
  - ➢ pursuing educational and professional development activities.

- Note that your treatment model may blind you to paying attention to self-care issues (Dana 2000).
- Also make self-care a priority at the team or community level (Maslach and Leiter 1997).
- Being aware of the risks of vicarious trauma may help in preventing the problem (Daniels et al. 2007).
- Providers may find themselves trying to avoid certain clients or topics (Shubs, 2008).
- Providers may find that they overly identify with the victim and become overwhelmed (Shubs 2008).
- Providers can also look toward the strengths they gain from working with victims (vicarious resilience) (Hernandez et al. 2007).

Spend time reading on self-care and try some of the activities suggested. Ask your colleagues what they do that helps them keep their life balanced.

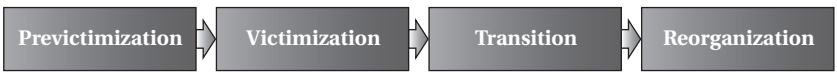
… *Sharpen Your Axe.*

2.0 A Model of Victimization and Recovery

In trying to understand the victim's experience, it is helpful to look at criminal victimization as a whole, not just the criminal event itself. Victimization includes how people deal with the stress of being victimized by something beyond their control. Before discussing the theories and research looking at victims, a key point needs to be highlighted: Not all crime victims are alike. This is the major point in this section, which looks at how each victim moves from the criminal event to recovery and getting back to so-called normal life. Whenever possible in this manual, the specific nature of the crime will be linked to the relevant research. However, the reality of reviewing research is that each study can set slightly different definitions for how they define the crime and crime victim. Thus, readers should recognize that each person will take a unique path, but there are some things that most victims will face in becoming a crime victim. This section focuses on some of these common elements.

As we try to understand our clients, we need to look closely at how people change psychologically as they are faced with a criminal event and begin to identify themselves as a "crime victims". Casarez-Levison (1992) reviewed several models of victimization. She developed a straightforward model of how people move from being a member of the general population to being a victim to becoming a survivor. She indicated that people move from a pre-crime state, to the crime event itself, to initial coping and adjustment, and finally to a state where being a crime victim is just part of their life experience (Casarez-Levison 1992).

Figure 1: The process of victimization and recovery (Casarez-Levison 1992)



Before the crime: Previctimization/organization

Before the crime, the person is basically living life – with a life history, strengths and weaknesses, a support system, financial pressures and so on. This includes any history of previous victimization, trauma and coping. This point is important, since research shows that victims of crime often have a history of previous victimization (Byrne et al. 1999;

Messman and Long 1996; Norris et al. 1997; Nishith et al. 2000). Workers need to know this, because how a person has dealt with previous victimizations may give clues about how he or she may handle current victimization and trauma (Casarez-Levison 1992). In fact, research has shown that having a poor reaction to previous trauma increases the chances that the victim will have a poor reaction to new trauma (Brunet et al. 2001).

The crime and after: Victimization/disorganization

The person is now faced with the crime. This might involve walking in to find that one's home has been burgled, being assaulted while walking home from the gym, etc. This stage may continue for a few hours or days as the victim tries to make sense of what happened. Greenberg and Ruback's (1992) research shows that victims' thinking shifts as they decide:

1) Was this a crime?
2) If yes, how serious was it?
3) How will I deal with the crime and my victimization?

The victim will base decisions on previous experiences, current level of emotional distress and knowledge about options. Options might include doing nothing, calling a friend, notifying police, re-evaluating the situation, or seeking a private solution. Greenberg and Ruback (1992) point out that victims don't necessarily pick the best option but, rather, the choice that meets a minimum set of requirements. Thus, a victim of date rape may decide to "just put the crime behind her" and not press charges because this meets the requirement of "no longer focusing on the violation." Further, given that victims are very open to the opinions of others during this time (Greenberg and Ruback 1992), even the perpetrator can sway decisions. In fact, in looking at why people report crime, influence from other people was more important than their personal emotional reaction or their expectation about police response (Greenberg and Beach 2004). Thus, workers could meet victims who are experiencing severe reactions weeks, months, or even years after the event (Thompson 2000) and who may not be aware that their problems relate to the victimization.

Given that it is often the victims who report the crime, these decisions can be crucial in how they deal with their distress. A 2004 survey of crime victimization among Canadians indicated that 88% of sexual assaults, 69% of household thefts, and 67% of personal property thefts

were not reported to authorities (Gannon and Mihorean 2005). Research on crime reporting reflects these different decision-making processes (Greenberg and Beach 2004; Greenberg and Ruback 1992). Buzawa, Hotaling and Byrne (2007) describe five general reasons people give for not reporting crimes: 1) do not want to involve authorities or use other forms of assistance; 2) do not see the offence as serious enough; 3) fear of retaliation from the offender; 4) do not believe the criminal justice system will help; and 5) do not feel the justice system will take into account their wishes.

In a survey of female victims of sexual assault, Monroe et al. (2005) found that 46.2% of those who indicated they were not going to file charges reported that it was because of their interview with police. Recent Canadian data indicates that crime victims have a more negative view of the effectiveness of the police than non-victims do (AuCoin and Beauchamp 2007). These situational factors and crime-related issues often influence whether the person decides to report the crime. For example, victims who know the perpetrator are less likely to report or seek help (Ullman 1999). It would be unsurprising to find that domestic violence victims are less likely to report the crime. Research also supports the view that others judge victims of date rape more harshly than victims of stranger rape (Abrams et al. 2003), which likely affects the victim's willingness to report the crime. These results will not surprise most workers who work with victims of domestic violence or date rape.

Once the person begins to identify as a crime victim, assuming the person is a victim, he or she will now follow a coping and decision-making path based on her pre-crime status (as stated above). However, victims are also likely to feel threatened, confused, helpless, angry, numb or fearful. They may have physical, emotional or mental injuries from any loss and be dealing with traumatic stress. The key is that the victim will likely cope using every skill he or she has (Casarez-Levison 1992).

Initial coping: Transition/ protection

After the initial reaction, the person is left to adjust to the long-term effects of the crime. This adjustment can start within a few weeks of the crime or up to six or even eight months later. This stage is similar to the previous stage, but now the victim is beginning the process of putting life back together. Basically, he or she has started to make sense of the victimization (meaning-making). Meaning-making has

often been seen as a part of grief work (Davis et al. 1998), a spiritual element of coping (Cadell, et al. 2003), and has been used in treating crime victims (Layne et al. 2001). Meaning-making is important to general crime victims (Gorman 2001), rape victims (Thompson 2000), and victims of any type of trauma (Nolen-Hoeksema and Davis 1999). In fact, it is often included as a major element in treatment interventions (Foy et al. 2001).

It is during this time that the victim will likely need the most help, either from friends and family or professionals. Support may help the person deal with stress, get information, and improve attempts to cope. Respect, honesty, and trust build emotional engagement, the basis of a good helping relationship. Emotionally engaged clients recover faster (Gilboa-Schechtman and Foa 2001). To be respectful of clients, workers should ensure that victims understand that treatment may mean getting worse before getting better (Nishith et al. 2002). Research has also shown that victims with extreme trauma symptoms, those with a history of childhood trauma due to sexual or physical abuse or witnessing family violence, and those who were physically injured during the crime may not be as responsive to standard treatment (Hembree et al. 2004). Workers should also be watchful for poor coping strategies such as drug and alcohol abuse, worsening of personal relationships, increased isolation or withdrawal (Casarez-Levison 1992). Further, workers should keep in mind that some victims may look as though they are doing well, but be hiding their problems under a calm exterior.

Although many victims may suffer from trauma as a result of being victims of crime, workers need to be wary of a "trauma bias" where one assumes that crime victims are automatically traumatized when they may not be (Nelson et al. 2002). Workers should remain sensitive to the possibility that certain victims may be hiding trauma while others are actually coping well. Respecting victims means that you must trust their self-assessment of their internal state. You can still provide support and education (Nelson et al. 2002) that helps your client cope. The goal of work during this stage is to increase positive coping behaviours and decrease ineffective or negative coping. This helps victims to rebuild their lives and move forward. However, if not handled well, they are unlikely to fully move into the final stage and may even reach a state of total exhaustion (Casarez-Levison 1992).

Moving forward: Reorganization/resolution

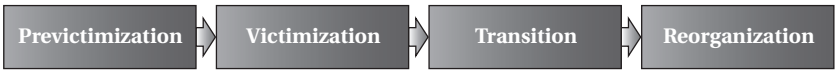
This period focuses on the victim rebuilding herself or himself into a stable functioning person who is doing well and has normal relationships. In the best cases, this may occur in 6 to 12 months; in worse cases, the process can take many years (Casarez-Levison 1992). Most people will face feelings of denial and acceptance around their experience. Workers will often find that victims ask questions about the world being a safe place, their new "survivor" role, and linking new experiences with pre-victim characteristics. Workers and victims need to understand that this rebuilding does not mean returning to "the past," as though the crime had never occurred. Being victimized changes how people view themselves and the world, and this makes it very unlikely that they will return to "pre-crime normal" (Norris et al. 1997). They need to understand the crime as something that happened and put it together with their understanding of the world. Workers should address poor responses, such as substance abuse and mental health problems as soon as possible, since these behaviours can delay moving forward (Casarez-Levison 1992). These poor responses should be addressed by teaching the victim new, more effective coping techniques.

On a positive note, research looking at sexual assault victims shows that interventions appear to be able to help victims many years after victimization (Resick, et al. 2002).

2.1 The Basics

- Casarez-Levison (1992) discussed victimization as a process where a person moves from a pre-crime state (Previctimization), to the crime event itself (Victimization), to initial coping and adjustment (Transition), and finally to a state where being a crime victim is just part of one's life experience (Resolution).

Figure 1: The process of victimization and recovery (Casarez-Levison 1992)



- Workers need to be cautious of engaging in "trauma bias" where one assumes that crime victims are automatically traumatized when they may not be (Nelson et al. 2002).
- Workers should ensure that victims understand that treatment may mean getting worse before getting better (Nishith, Resick and Griffin 2002).
- Workers should be watchful of poor coping strategies such as drug and alcohol abuse, worsening of personal relationships, increased isolation or withdrawal (Casarez-Levison 1992). These poor responses should be addressed as quickly as possible by teaching the victim new, more effective coping techniques.
- Victims do not return to a pre-crime state – they need to make sense of the crime and its effects, and this becomes part of their life experience (Norris et al. 1997).
- Interventions appear to be able to help victims many years after victimization (Resick et al. 2002).

3.0 Common Reactions to Crime

It is useful to know the common reactions that victims may experience when trying to cope with the crime. Keep in mind that each victim will have his or her own unique path towards recovery, but being aware of common reactions can help workers better help victims recover. Research indicates that about 25% of victims of violent crime reported extreme levels of distress, including depression, hostility, and anxiety (Norris et al. 1997). Another 22% to 27% reported moderate to severe problems. This means that around 50% of victims of violent crime report moderate to extreme distress. Table 1 shows the reactions that researchers and theoreticians have observed in crime victims. Workers may also recognize these reactions in the victim's friends and family, since crime affects family and friends, school, work and the broader community (Burlingame and Layne 2001).

Anger

The issue of anger as a reaction is notably more complicated than one might at first assume. Researchers often link anger to property crime and fear to violent crime (Greenberg and Ruback 1992). However, anger is basically a reaction wherein people feel cheated out of something they feel they deserved. In the case of criminal victimization, they have been cheated out of their feelings of safety and fairness and belief in a just world, etc. Thus, anger can be a reasonable reaction to any type of crime. In life, anger can act as a motivator to change. Greenberg and Ruback (1992) point out that many victims create internal fantasies about getting revenge or justice. If these fantasies have positive outcomes (e.g. the perpetrator is caught), they may increase the chance the victim will take action. Thus, so-called righteous anger can help the person move forward, feel energized, to deal with the criminal justice system or get help. On the other hand, researchers have examined post-traumatic stress disorder and anger/revenge/retaliation fantasies in victims of violent crimes (Orth et al. 2008; Orth et al. 2006). They concluded that anger and revenge fantasies may initially make victims feel better, but may cause problems if the person continues to think about the crime and cannot move forward. Under this view, the timing and content of anger management programs may be very important in helping victims become healthy.

Table 1: Common reactions to crime victimization

Mood/Emotions	Social	Thinking/ Memories	Physical
Fear/phobias [1, 3, 4, 5, 8, 9, 10, 16, 17, 18, 19, 21, 25, 28, 13, 14, 31,]	Changes in relating to people [2, 6 19, 28, 13, 14]	Intrusive memories [2]	Nausea [1, 13,]
Anger/hostility [1, 2, 3, 4, 7, 18,19 20, 24, 28, 31]	Avoidance [5, 7, 13]	Lower self-efficacy [2, 28,]	Stomach problems [1, 13, 21]
Embarrassment [1]	Alienation [5, 17]	Vigilance [2, 13]	Muscle tension [1]
Anxiety [2, 5, 7, 13,27]		Flashbacks [5, 13,]	Sleep problems [2, 13]
Depression [2, 4, 6, 16, 18, 19, 20, 22, 13, 27]		Confusion/poor concentration [4, 5, 13]	Weight loss [17, 19]
Grief [1, 2, 4 21, 24, 26, 13, 14]		Dissociation [4, 31, 13]	Headaches [17, 19]
Guilt, shame [4, 5, 6, 11, 12, 15, 29, 30]		Questioning spiritual beliefs [13]	Faintness or dizziness [13]
Difficulty controlling emotions [4]			Hot or cold bodily sensations [13]
Apathy/ numbness [5, 13]			
Lower self-esteem [7, 15, 17, 19, 23]			

Table 1: Common reactions to crime victimization *(cont.)*

[1] Casarez-Levison (1992)
[2] Everly et al. (2000)
[3] Greenberg and Ruback (1992)
[4] Leahy et al. (2003)
[5] Mezy (1988)
[6] Nishith et al. (2002)
[7] Norris et al. (1997)

Updated references:

[8] Amstadter et al. (2007)
[9] Boccellari et al. (2007)
[10] Boeckmann and Turpin-Petrosino (2002)
[11] Courtois (2004)
[12] Danieli et al. (2004)
[13] Daniels et al. (2007)
[14] DeValve (2005)
[15] Dunbar (2006)
[16] Gabriel et al. (2007)
[17] Garnetts et al. (1990)
[18] Herek et al. (1997)
[19] Janoff (2005)
[20] Lebel and Ronel (2005)
[21] Manktelow (2007)
[22] Miller and Heldring (2004)
[23] Mock (1995)
[24] Nordanger (2007)
[25] Orth et al. (2008)
[26] Pivar and Prigerson (2004)
[27] Spataro et al. (2004)
[28] Staub (1996)
[29] Thielman 2004
[30] Wertheimer (1990)
[31] Young et al. (2007)

That said, workers need to be careful of confusing anger with empowerment. If not handled properly, chronic anger can be very harmful to the victim. Workers may want to focus on anger issues if they see the anger as becoming longstanding and interfering with the person's healing process. Each victim must be treated as an individual. Workers should help the victim learn to manage all emotions in a way that helps in coping with challenges while remaining healthy. This will help the victim move forward and rebuild his or her life. Anger can be a challenging emotion to face, even for the most skilled clinicians. All workers, regardless of training, should reflect on whether they are able to help victims in this area. If not, they need to refer clients to other professionals.

3.1 Severity of Reaction

Severe reactions can be overwhelming to workers. As reactions become less severe, they do not necessarily become easier for victims. This mismatch poses a challenge both to workers and to victims. Research indicates that violence during the crime increases the severity of the response; victims of non-violent crime, however, also fear for their safety, and can have increased psychological symptoms (Green and Pomeroy 2007b; Norris et al. 1997). Crime-related characteristics may also affect the severity of the reaction. (Steel et al. 2004) found that the number of offenders and the duration of

childhood sexual abuse were directly related to psychological distress in both male and female victims. Workers need to pay attention to what the victim reports and use that information to help inform assessments of severity.

Although there is no overall pattern based on victim type, all victims of crime experience distress. The general finding that the more violent the crime, the more severe the reaction offers workers insight into what to expect about client reactions. Thus, a victim of a violent crime who reports that he or she feels no distress may need closer monitoring. The report may be valid, but should be examined in relation to coping skills, current behaviour, and life experience. Workers need to work with clients to help them understand distress levels, how the crime has affected their lives, and what they can do to move forward

Victims are the best source of information about what is happening in their own lives. Recent Canadian data indicates that 21% of crime victims say that their life was not affected much by the crime (AuCoin and Beauchamp 2007). This same survey looked at victims of violent crime and found that approximately 60% of women and 70% of men reported that their daily activities were not disrupted. Workers should be aware that many victims do not report higher levels of distress (remember: be aware of trauma bias; Nelson et al. 2002). Research on female sexual assault victims found that they experience more severe reactions and take longer to heal than non-sexual assault victims (Gilboa-Schechtman and Foa 2001). Both groups had similar levels of post-traumatic stress disorder (PTSD) and anxiety, but the sexual assault group showed higher levels of depression.

Gilboa-Schechtman and Foa (2001) also examined “peak reactions” which may be of interest to workers. Peak reactions refer to the point at which the victim experiences the strongest symptoms. They found that the longer a woman took to have her peak reaction, the more symptoms she experienced. In other words, those who experienced the strongest symptoms shortly after the assault had lower levels of depression and PTSD. Thus, workers should watch a victim’s symptoms closely and pay particular attention to victims who are having intense symptoms long after the crime. These clients may benefit from more intensive treatment from mental health professionals.

What workers need to take away from this research is that the unique experience of some people makes one-to-one attention an extremely important part of treatment. Thus, even in a group setting, workers should work to monitor and check in with all clients, not just those who seem to be experiencing problems during a particular session.

Fortunately, group interventions can be helpful, since all victims will have some reaction to dealing with the crime and its effects. However, workers need to be wary of mixing those with highly severe reactions to those with less severe reactions. Social comparison could negatively affect either group (Greenberg and Ruback 1992). Those with more severe reactions may feel that they should be "stronger," and those with less severe reactions could fear that they will get worse. It may not be possible to have groups for different levels of severity. Workers need to be aware of this challenge and make sure that victims understand that reaction to victimization is very much an individual path. It is important for group work to emphasize that victims can learn something from each other.

A final point on severity: in a large-scale study, Pimlott-Kubiak and Cortina (2003) examined assault history and gender. In grouping their sample of 16,000 people (8,000 women and 8,000 men), they found that most men and women reported little or no victimization. Of those who reported victimization, two groups were over 90% female: those reporting primarily sexual assault; and those reporting repeated violence that included sexual violence. Both of these groups would likely experience severe reactions. This research probably reinforces workers' experience of seeing mostly female victims in daily practice. Men were more likely to be in the group who described physical abuse in childhood (67% male) and repeated violence that did not include sexual violence (66% male) (Pimlott-Kubiak and Cortina 2003). Although any good assessment needs to ask about a wide variety of issues, workers working with women need to ask about sexual assault either as a single event, or as part of several violent assaults. When working with men, we need to be more aware of a history of physical abuse in childhood and repeated violence. These results remind us that we need to go beyond the specific crime and ask about trauma history and to use this in our interventions.

Client matching

A major reason for looking at severity of reaction is to develop ideas of how to best help victims rebuild their lives. Some victims may benefit the most from relatively minor interventions, for example, sharing information. Others with more severe reactions might require more intensive support that might be provided in a peer group. Finally, there are those clients experiencing severe reactions that may require a referral to mental health counselling or even hospitalization. It would not make sense to only give information to someone experiencing severe distress, nor would it make sense to require a person coping well to enter therapy. Table 2 describes a model to help workers think about these issues. The key element to understand is that crime victims are a diverse group with diverse needs. This diversity requires workers to adapt to the victim in providing those services that best meet the victim's needs. It may be helpful for offices to review their programs and materials to see if there are any gaps in services that relate to the various need levels (e.g. clear strategies for low- and high-need clients, but fewer for moderate-need clients).

Secondary victimization

Secondary victimization is related to severity as it can worsen an already difficult situation. Basically this happens when the victim comes into contact with professionals and paraprofessionals and is further traumatized by their response. This can happen through retelling the victim's story, being treated unfairly or experiencing other behaviours that make him or her feel as though people aren't listening or don't believe the story. It is noteworthy that victims who described police as "helpful" felt more connected to others (Norris et al. 1997). However, negative experiences with professionals increased post-traumatic stress symptoms (Campbell et al. 1999) and decreased the likelihood of reporting (Monroe et al. 2005). It is fortunate that those victims who received mental health services after having a negative experience with the system showed decreased distress (Campbell et al. 1999). Some have called for increased training for first-responders (police, emergency room staff) who are likely to encounter victims of crime (Cederborg and Lamb 2008; Hamberger and Phelan 2006).

Table 2: Severity by Service type: A proposed model

Needs Level	Description	Possible service options
Low	They are coping well with few symptoms, easily managed through natural coping skills and social support. They may not have experienced a severe crime and/or may have many ways to cope.	Minimal services: information sharing – provide written material, brochures of available supports, and education about signs of deeper problems. These services would also be useful for those who do not feel they have any problems, but are trying to hide their suffering. These same written materials might be given to people in the victim's support system.
Moderate	Experiencing some symptoms and need to expand coping skills or need a place to deal with overwhelming emotions. Generally, they cope well but are overwhelmed by being victimized.	Peer-run support groups, paraprofessional and volunteer support. Some professional support may be needed, but only on a short-term basis.
High	Experiencing many symptoms or problems and displaying poor coping behaviours. Overwhelmed by being victimized and with few effective supports. Severe trauma may have occurred. Likely evidence of multiple problems and multiple victimizations.	Need for professional treatment. This may include long-term individual or group therapy or even hospitalization to help the person stabilize.

3.2 Previous Victimization

Researchers have found that some people become victimized again and again throughout their lives (Byrne et al. 1999; Messman and Long 1996; Norris et al. 1997; Nishith et al. 2000; Peleikis et al. 2004). The relationships between trauma incidents are quite complex: new victimization interferes with the person's ability to cope with past trauma; and previous victimization affects how he or she will cope with the new trauma. In effect, the repeated victimizations interrupt the person's normal healing process, especially if the revictimization occurs in a relatively short period after initial victimization (Winkel et al. 2003).

Norris et al. (1997) noted that crime victimization challenges peoples' views of themselves or their worlds. Several studies report that previous victimization is a very strong, and possibly the strongest, predictor of further victimization (Byrne et al. 1999; Messman and Long 1996; Norris et al. 1997; Nishith et al. 2000). Research examining women in violent relationships found that many had been victims of childhood victimization and that the specific type of abuse or neglect increased the chances of different problems in adulthood: sexual abuse increased anxiety, whereas emotional neglect increased dissociation and depression (Lang et al. 2004). Female survivors of childhood sexual abuse are at increased risk of later sexual assault (Peleikis et al. 2004). Furthermore, previous victimization seems to affect the victim's reaction to new victimization, and reduce their willingness to report the crime to authorities (Buzawa et al. 2007). Researchers have theorized that low self-esteem, learned helplessness, poor relationship skills and choices, difficulty reading risky situations, or poverty may affect the choices made by the revictimized person (Byrne et al. 1999; Messman and Long 1996; Nishith et al. 2000).

Furthermore, those victims who had a very bad reaction to previous trauma are likely to have a bad reaction to new trauma (Brunet et al. 2001). Basically, revictimization gets in the way of the their ability to rebuild themselves and their lives. Workers need to ask about previous traumas (both crime-related and otherwise) and focus on details that might give clues on how best to help victims meet their needs. In addition, following-up with questions about how the victim normally handles stressful situations should also help workers to better predict how their client will react to the current trauma.

3.3 Diagnoses Commonly Applied to Crime Victims

Workers can benefit from having a basic understanding of diagnostic terms that they may encounter in files or in speaking to mental health professionals. Diagnoses commonly linked to being a crime victim include anxiety and post-traumatic stress disorder (PTSD) and depression (definitions in Figures 2 and 3).[4] Researchers have noted that these problems can appear in victims of workplace violence (Rogers and Kelloway 2000), stalking (Löbmann et al. 2003; Pimlott-Kubiak and Cortina 2003), sexual assault (Byrne et al. 1999), childhood sexual abuse (Hembree et al. 2004; McDonagh et al. 2005; Merrill, Thomsen, Sinclair, Gold and Milner 2001; Peleikis et al. 2004), childhood physical abuse (Hembree et al. 2004), violent crime (Byrne et al. 1999), gang-related violence (Ovaert, Cashel and Sewell 2003), and family violence (Chemtob and Calson 2004; Hembree et al. 2004; Wolkenstein and Sterman 1998). PTSD is often discussed as related to victimization, especially when violence occurs (Byrne et al. 1999). Several researchers have noted success in reducing PTSD symptoms through treatment. Successful treatments often include opportunities for the victim to share the trauma story while applying new skills to manage feelings and thoughts (Amstadter et al. 2007; Bryant et al. 2003; Hembree and Foa 2003; Nishith et al. 2002).

Furthermore, many crime victims will be dealing with grief, especially those whose loved ones were victim of homicide (Miller 1998). Grief is a normal reaction to loss; however, the normal healthy grieving process can be complicated by many issues, including victimization. Miller (1998) indicates that along with the feelings of sadness, anxiety, and guilt often seen in grief, survivors of homicide victims can also experience fear and an extreme need to keep themselves and other loved ones safe. Within mental health circles, one may speak of grief or complicated grief. Pivar and Prigerson (2004) describe complicated grief as having symptoms that do not decrease in intensity or frequency, are longer in duration (from two to six months) and interfere with the person's work, school, social or home life (Pivar and Prigerson 2004). In people who have lost a loved one, workers should watch for a) loneliness, b) intruding thoughts about the person, c) yearning for the person, and d) searching for the person. Other

4 Workers may also encounter the term acute stress disorder, which has similar symptoms as PTSD but lasts less than a month (Brewin et al. 2003)

symptoms that should tip workers to refer to mental health professionals are:

- purposelessness or feelings of futility about the future;
- feeling numb or detached;
- difficulty acknowledging the death;
- feeling that life is empty or without meaning;
- feeling that part of oneself has died;
- having a shattered world view (loss of sense of security, trust, control);
- assuming symptoms or harmful behaviours of the deceased person; and
- excessive irritability, bitterness, or anger related to the death. (Pivar and Prigerson 2004, 279).

Figure 2: Anxiety and Post-Traumatic Stress Disorder (PTSD)

It must be emphasized that PTSD is a specific type of anxiety. Anxiety and fear can appear as intense fear of specific situations or public places, panic attacks, general fear and anxiety and PTSD.

Most anxiety disorders include symptoms such as:

- fear, distress or worry;
- physical problems (e.g. sweating, shaking, difficulty breathing, nausea, chest pain, dizziness);
- behaviour change (e.g. avoidance, rituals); and
- behaviours aimed at reducing distress (American Psychiatric Association 1994).

PTSD occurs after a traumatic event and symptoms may include such anxiety symptoms as:

- fear;
- helplessness;
- intrusive and recurrent recollections;
- distressing dreams;
- reliving of the event;
- intense distress;
- physiological reactions;
- avoidance or suppression of thoughts or feelings; and
- specific symptoms such as sleep problems, irritability, angry outbursts, poor concentration, hypervigilance, and exaggerated startle response (American Psychiatric Association 1994).

Figure 3: Depression

Depressive symptoms may include:
- low mood;
- low appetite or weight loss;
- sleep problems;
- energy changes;
- self-blame or feelings of guilt;
- feelings of worthlessness or hopelessness;
- difficulty concentrating; and
- thoughts of death.

(American Psychiatric Association 1994)

It is important to recognize that you cannot directly compare one loss to another. Workers should also be aware of the cultural norms of the victim to understand the difference between normal and complicated grief (American Psychiatric Association 1994; Nordanger 2007; Pivar and Prigerson 2004). An easy guideline when dealing with this issue is to use the person's own definition of whether he or she is overwhelmed by grief and needs help. It can also be helpful for workers to consult with experienced colleagues or ask members of the culture about what is normal in their group. You might also rely on these sources to recommend culturally relevant rituals or support people (Nordanger 2007). In these consultation situations, you should always work to protect the confidentiality of your client.

Researchers have found that criminal violence and negative coping predict PTSD, anxiety and depression to varying degrees (Dempsey 2002; Green and Pomeroy 2007b). Daley et al. (2000) found that more chronic stressors, such as the stress experienced by a victim of family violence, are more likely to wear down the victim, whereas an acute stress, such as single-episode assault by a stranger, may deepen feelings of depression. In a study of adolescents who were victims of violence, Kilpatrick et al. (2003) found that almost 75% of adolescents who had PTSD also had either substance abuse problems or depression. Some researchers recommend that treatment efforts in these cases should target the substance use and PTSD at the same time to increase the chances of success (Amstadter et al. 2007). Gilboa-Schechtman and Foa (2001) noted that victims of sexual assault, versus non-sexual assault, were more likely to experience depression. They theorized that anxiety and PTSD are common to all traumas, but that depression is related to certain types of trauma, such as sexual assault (Gilboa-Schechtman and Foa 2001).

One question that is often raised when examining PTSD is "Why does one person develop the disorder while others do not?" Research has linked the following to increased chances of developing PTSD or interfering with recovery:

- Crime- or trauma-related factors (e.g. trauma severity related to sexual assault) (Brewin, et al. 2000; Gilboa-Schechtman and Foa 2001; Ozer et al. 2003)
- Perpetrator being known to the victim (Gutner et al. 2006) or a relative (Ullman et al. 2006)[5]
- Lack of social support (Brewin et al. 2000; Gutner et al. 2006; Ozer et al. 2003) or poor reaction from supports (Mueller et al. 2008)
- Additional life stress (Brewin et al. 2000; Ozer et al. 2003)
- Previous PTSD (Brunet et al. 2001; Ozer et al. 2003)
- Dissociation during or immediately following the crime (Ozer et al. 2003)
- Report of childhood abuse (Brewin et al. 2000; Hembree et al. 2004; Peleikis et al. 2004)

Researchers have noted a lesser link between the following and PTSD:

- Previous trauma (Brewin et al. 2000; Ozer et al. 2003; Scarpa et al. 2006)
- Personal psychiatric history (Brewin et al. 2000; Ozer et al. 2003), depression in particular (Ozer et al. 2003)
- Family psychiatric history (Brewin et al. 2000; Ozer et al. 2003)
- Education (Brewin et al. 2000)
- General childhood adversity (Brewin et al. 2000)
- Gender (Brewin et al. 2000)
- Age at time of trauma (Brewin et al. 2000)
- Race (Brewin et al. 2000)

Fortunately, mental health professionals can help clients with these disorders. Both medical and psychological treatments can be effective. Researchers collaborate with clinicians to develop the best treatment possible. For example, effective PTSD treatment often includes an exposure element wherein the person needs to psychologically face the fear and anxiety by discussing or talking about the crime and crime-related reminders (Bryant et al. 2003; Hembree and Foa 2003; Kamphuis and Emmelkamp 2005; Kubany et al. 2004; McDonagh et al. 2005; Nishith et al. 2002). Workers not trained in these issues need to

5 Ullman et al. (2006) also found that victims of perpetrators who were strangers showed increased PTSD symptoms.

keep in mind the importance of consultation and making appropriate referrals to mental health professionals. This is especially important because many victims may have a combination of disorders (PTSD, other anxiety disorders, depression, substance abuse, personality disorders, etc.) that may affect how they respond to interventions (Amstadter et al. 2007; Chemtob and Calson 2004; Clarke et al. 2008).

A relatively recent treatment approach for trauma that workers may have heard discussed is called Eye-Movement Desensitization and Reprocessing or EMDR (Shapiro 1995). Although it is beyond the scope of this manual to detail any one treatment, EMDR is gaining in popularity and workers may have some clients undergoing this treatment. Briefly, in EMDR the therapist asks the client to focus on the traumatic event (images, thoughts, etc.), evaluate the negative qualities, and change his or her thinking about the trauma or his reaction during the trauma. While this is happening, the therapist gets the client to visually track a finger rapidly waved back and forth in front of the face (Shapiro 1995). There is much debate in the literature about what makes EMDR work, but outcome studies with victims of crime show reduced PTSD symptoms when compared to wait-list controls and similar results to other PTSD treatments (Hembree and Foa 2003).

Workers will also want to consult with healthcare professionals when working with families or children who were criminally victimized. Children will often have similar reactions to crime victimization as adults (Cohen et al. 2003). However, there can be important developmental issues that experts in child development will be able to assess (Pine et al. 2005). Despite these issues, workers may find that the treatments professionals provide children are similar to those adults receive (Cohen et al. 2003).

3.4 When to Refer to Mental Health Professionals

With respect to seeking help, Norris et al. (1997) found that about 12% of victims sought mental health services. Most of these were victims of violent crime. They found that violence and depression were the biggest predictors of seeking help. It is worth noting that they also found that professional help was only effective if the help was prompt and ongoing (Norris et al. 1997). Most Canadian victim services agencies (81%) indicate that they are able to help victims with mental health difficulties, mostly by partnering with mental health services (Brzozowski 2007).

Mental health workers can provide support for more-challenging clients. Although many victims can benefit from traditional services, some may need the more intensive treatment that professionals trained to deal with mental health issues can provide. These include victims who may have a mental illness, intense stress reactions, complicated grief, complex life histories or other problems. As Lawson (2001) noted, most professionals are trained to understand different types of abuse, can help clients process emotions, can teach skills and help with planning/problem solving. Professionals can also help victims identify and use social support systems, and act as an additional support to the natural supports. Basically, professionals can work with the client to help them cope (Gorman 2001).

Understanding your limits is an important part of being an effective worker. You need to use consultation from both your supervisors and co-workers to understand your limits. Thus, there are no set rules as to when to refer your client to more professional services. However, there are some issues that should make you think about whether bringing someone else in may be in your client's best interest. Obviously, the resources and supports available in your area will also affect what other supports you and the victim can access. This does not mean that you cannot support the client but, rather, that you should consider a referral to mental health professionals when you feel you need help. The following list identifies situations that might require a referral:

1. You suspect the person has depression, anxiety, post-traumatic stress disorder, continued dissociation or other mental health problems (especially if substance misuse is also present).
2. There are complicated grief issues that interfere with moving forward.
3. Suicide or self-harm is a concern.
4. Retaliation, or harming others, is a concern (which may require contacting the police or other authorities as well).
5. Intense emotions (anger, sadness, grief) are beyond your skills or resources.
6. The person seems to be unmotivated and stuck.
7. The person does not seem to get as much from group, self-help, or other interventions.
8. The person does not seem to be getting better even though apparently motivated and working hard.
9. The person has a long, complicated history of victimization or abuse.

10. The person has a long history of mental health or substance-abuse problems.

Those working in more isolated areas should contact their local health care professionals for help in solving problems about how to best meet the needs of victims in general. These partnerships can be invaluable in providing new information and professional support. Isolated workers might also use strategies such as telehealth consultation (using phone, e-mail or video-conferencing) to get guidance or receive consultation or supervision. Telehealth systems can also be used to deliver therapy, with the local supports working with the victim and possibly participating in therapy with a professional in another area. Other possibilities include bringing in professionals to conduct workshops, crisis treatment or supervision sessions. It is important for workers to be cautious about digging deeply into complex victims issues without backup. Sometimes this cannot be avoided, since the victim may be ready to deal with these issues. It is important for workers to ensure that they consult with others when outside their areas of expertise. Acting ethically and being respectful of your clients includes being aware of your own limits.

3.5 The Basics

Reactions

- As people deal with having been victimized, workers can identify common reactions. These reactions are normal, but may still mean that the victim requires help to deal with being overwhelmed. Table 1 lists some common reactions discussed in research.

- Anger is a difficult emotion for the victim and also for the supports and workers. Much care is needed to make sure that it is handled properly (Greenberg and Ruback 1992). Workers should understand that anger is a natural reaction to victimization, but that it can also interfere with getting better. Thus, there is no easy answer to how to handle anger; training, judgment and empathy are your best tools for deciding how to help victims showing anger. Supervision/consultation will be key in dealing with your reaction to anger and other emotions.

Table 1: Common reactions to crime victimization

Mood/Emotions	Social	Thinking/ Memories	Physical
Fear/phobias [1, 3, 4, 5, 8, 9, 10, 16, 17, 18, 19, 21, 25, 28, 13, 14, 31,]	Changes in relating to people [2, 6 19, 28, 13, 14]	Intrusive memories [2]	Nausea [1, 13,]
Anger/hostility [1, 2, 3, 4, 7, 18,19 20, 24, 28, 31]	Avoidance [5, 7, 13]	Lower self-efficacy [2, 28,]	Stomach problems [1, 13, 21]
Embarrassment [1]	Alienation [5, 17]	Vigilance [2, 13]	Muscle tension [1]
Anxiety [2, 5, 7, 13,27]		Flashbacks [5, 13,]	Sleep problems [2, 13]
Depression [2, 4, 6, 16, 18, 19, 20, 22, 13, 27]		Confusion/poor concentration [4, 5, 13]	Weight loss [17, 19]
Grief [1, 2, 4 21, 24, 26, 13, 14]		Dissociation [4, 31, 13]	Headaches [17, 19]
Guilt, shame [4, 5, 6, 11, 12, 15, 29, 30]		Questioning spiritual beliefs [13]	Faintness or dizziness [13]
Difficulty controlling emotions [4]			Hot or cold bodily sensations [13]
Apathy/ numbness [5, 13]			
Lower self-esteem [7, 15, 17, 19, 23]			

Table 1: Common reactions to crime victimization *(cont.)*

[1] Casarez-Levison (1992)
[2] Everly et al. (2000)
[3] Greenberg and Ruback (1992)
[4] Leahy et al. (2003)
[5] Mezy (1988)
[6] Nishith et al. (2002)
[7] Norris et al. (1997)

Updated references:

[8] Amstadter et al. (2007)
[9] Boccellari et al. (2007)
[10] Boeckmann and Turpin-Petrosino (2002)
[11] Courtois (2004)
[12] Danieli et al. (2004)
[13] Daniels et al. (2007)
[14] DeValve (2005)
[15] Dunbar (2006)
[16] Gabriel et al. (2007)
[17] Garnetts et al. (1990)
[18] Herek et al. (1997)
[19] Janoff (2005)
[20] Lebel and Ronel (2005)
[21] Manktelow (2007)
[22] Miller and Heldring (2004)
[23] Mock (1995)
[24] Nordanger (2007)
[25] Orth et al. (2008)
[26] Pivar and Prigerson (2004)
[27] Spataro et al. (2004)
[28] Staub (1996)
[29] Thielman 2004
[30] Wertheimer (1990)
[31] Young et al. (2007)

Severity of Reaction

All victims of crime experience some distress (Norris et al. 1997). Research indicates that violence during the crime increases the severity of the reaction and about 50% of victims of violent crime report moderate to severe reactions (Norris et al. 1997).

Victims of sexual assault reported more severe reactions and took longer to heal than victims of non-sexual assault (Gilboa-Schechtman and Foa 2001).

Workers need to be careful of groups that mix victims who have severe reactions with those that have less severe reactions. Social comparison (feeling better off or worse off) with other group members may interfere with treatment if not handled properly (Greenberg and Ruback 1992). Workers should think about how to best match client needs to service level for their clients' benefit (see Table 2).

- Women may be at risk for more severe reactions since they are more likely than men to experience sexual assault or repeated victimizations (including sexual assault) (Pimlott-Kubiak and Cortina 2003).

- Professionals need to be careful of causing the victim even more distress (secondary victimization) by not being sensitive to the victim's state of mind (Campbell et al. 1999).

Table 2: Severity by Service type: A proposed model

Needs Level	Description	Possible service options
Low	They are coping well with few symptoms, easily managed through natural coping skills and social support. They may not have experienced a severe crime and/or may have many ways to cope.	Minimal services: information sharing – provide written material, brochures of available supports, and education about signs of deeper problems. These services would also be useful for those who do not feel they have any problems, but are trying to hide their suffering. These same written materials might be given to people in the victim's support system.
Moderate	Experiencing some symptoms and need to expand coping skills or need a place to deal with overwhelming emotions. Generally, they cope well but are overwhelmed by being victimized.	Peer-run support groups, paraprofessional and volunteer support. Some professional support may be needed, but only on a short-term basis.
High	Experiencing many symptoms or problems and displaying poor coping behaviours. Overwhelmed by being victimized and with few effective supports. Severe trauma may have occurred. Likely evidence of multiple problems and multiple victimizations.	Need for professional treatment. This may include long-term individual or group therapy or even hospitalization to help the person stabilize.

Previous Victimization

Researchers have found that previous victimization is a very strong predictor of further victimization (Byrne et al. 1999; Messman and Long 1996; Norris et al. 1997; Nishith et al. 2000). Victims who have had a bad reaction to previous trauma are likely to have a bad reaction to new trauma (Brunet et al. 2001).

Previous victimization tends to affect the victim's reaction to new victimization, perhaps through low self-esteem, habits of learned helplessness, poor relationship skills or choices, difficulty in reading risky situations, or poverty (Byrne et al. 1999; Messman and Long 1996; Nishith et al. 2000). These results remind us that we need to go beyond the specific crime and ask about trauma history and to use this information in our interventions.

Common Diagnoses of Victims of Crime

Diagnoses commonly linked to being a crime victim include depression, anxiety, and post-traumatic stress disorder (PTSD).

Depression symptoms can include low mood, low appetite or weight loss, sleep problems, energy changes, self-blame or feelings of guilt, feelings of worthlessness or hopelessness, difficulty concentrating, and thoughts of death (American Psychiatric Association 1994).

Anxiety symptoms can include fear, distress, and worry or physical symptoms (e.g. sweating, shaking, difficulty breathing, nausea, chest pain, dizziness), behaviour change (e.g. avoidance, rituals) and behaviours that try to reduce distress (American Psychiatric Association 1994).

PTSD is a form of anxiety disorder that is linked to a specific incident, such as a crime, natural disaster, or accident (American Psychiatric Association 1994). PTSD may include such symptoms as fear, helplessness, intrusive and recurrent memories, nightmares, reliving the event, intense distress, being jumpy, avoidance or suppression of thoughts or feelings, and specific symptoms such as sleep problems, irritability, angry outbursts, poor concentration, hypervigilance and exaggerated startle response (American Psychiatric Association 1994).

Complicated grief, or intense grief that goes on for a long time, can be a problem for some victims and their survivors.

Risk factors for developing PTSD include crime- or trauma-related factors (Brewin et al. 2000; Gilboa-Schechtman and Foa 2001; Ozer et al. 2003); a lack of social support (Brewin et al. 2000; Ozer et al. 2003); additional life stress (Brewin et al. 2000; Ozer et al. 2003); previous PTSD (Brunet et al. 2001; Ozer et al. 2003); and dissociation during or immediately after the crime (Ozer et al. 2003).

When to Refer to Mental Health Professionals

Workers should carefully consider when to refer clients to mental health professionals.

If they are not trained in mental health issues, workers should consult and make appropriate referrals to professionals. Partnerships with healthcare and telehealth, consultation, and visiting professionals are possible solutions for workers in isolated areas.

4.0 How do Victims Cope?

Workers should also be aware of how victims cope. The victim faces many different challenges: the shock of being victimized, dealing with the police and courts, the reactions of others, returning to "normal," feeling unsafe, self-blame and so on. Researchers note that victims don't seem to return to pre-crime levels of stress, although they can manage to function relatively well (Hagemann 1992; Norris et al. 1997; Resick et al. 2002). Although the passage of time may give a victim the opportunity to return to a "normal" life, victimization appears to have long-lasting effects (Gilboa-Schechtman and Foa 2001; Norris et al. 1997). By understanding coping options for victims, workers can help victims use this time to explore options and learn new, more effective coping strategies. Also, monitoring the use of these strategies helps workers assess client progress, because research shows that victims use coping techniques less and less as they get better (Calhoun and Atkeson 1991).

In addition, regular life stress is often overlooked when we focus on victim distress and coping. Victims of crime continue to deal with the same family, relationship and life stress as other people. Thus, the stress of being a crime victim is piled on top of the other stressors. Recent research has found that victims of crime who are employed are at increased risk of using poorer coping strategies (Boccellari et al. 2007). These researchers theorize that this is because added work stress interferes with effectively choosing healing strategies. Workers are reminded to look beyond the crime-related distress and coping to other stressors in the person's life. They can then direct clients to appropriate supports. For example, a victim with poor reading skills who cannot read self-help booklets or fully participate in support groups could be referred to community literacy programs.

Before discussing specific coping strategies, we need to make a key distinction. The research literature highlights the differences between positive and negative coping. Positive coping focuses on changing ourselves or dealing directly with the problem (e.g. social support, problem-solving efforts, seeking information). Negative coping generally does not focus on the stressor or our reaction to it (e.g. blaming others, withdrawal, resignation, self-criticism, aggression, wishful thinking, use of alcohol or drugs). Dempsey (2002) found that using negative coping strategies could make the person feel worse.

This positive-negative distinction is not clear-cut. Some researchers have noted that certain coping strategies, such as avoidance or dissociation, may be helpful in dealing with the initial shock but become damaging as time passes (Hagemann 1992; Harvey and Bryant 2002; Ullman 1999). Further, cultural norms can be a factor as well, in that coping strategies seen as negative in general Canadian society might be seen as normal in certain subcultures (see Nordanger 2007 for a discussion on avoidance and grief).

Workers need to assess each person to decide if his or her coping strategies are helping survival or progress or if it is getting in the way. Think of the victim as someone hanging off a cliff and holding onto a weak branch: it may not seem safe, but until there is another more trustworthy option, the person will not let go! Workers need to work with their clients to help them replace coping strategies that are not working with more positive options – not just remove the negative strategies. Remember, victims of crime are a diverse group, and workers need to assess each person in order to understand his or her particular reaction. Table 3 lists common coping strategies that victim of crime might use. I will briefly discuss each in turn.

Table 3: Common Coping Strategies

Positive Coping Strategies	Negative Coping Strategies
Information seeking [5]	Avoiding reminders of the crime [2, 5, 13, 20, 21, 22, 25, 26, 27, 28]
Self-comparison/emphasizing the positive aspects of surviving [1, 5, 11, 19]	Behavioural avoidance - Use of drugs/alcohol
Social comparison [4, 5, 8, 19]	Denial and self-deception [13, 18, 19, 20, 26]
Activities to regain control [4, 5, 26]	Dissociation [6, 10, 15]
Activism [5]	Obsessing about the crime [4, 7]
Time to heal [3, 5, 15, 17]	Self-harm [29, 30]
Emotion-focused coping [23, 24]	
Getting support [2, 4, 9, 14, 15, 23, 24]	

Table 3: Common Coping Strategies, (*cont.)*

[1] Davis et al. (1998)
[2] Everly et al. (2000)
[3] Gilboa-Schechtman and Foa (2001)
[4] Greenberg and Ruback (1992)
[5] Hagemann (1992)
[6] Harvey and Bryant (2002)
[7] Holman and Silver (1998)
[8] Layne et al. (2001)
[9] Leymann and Lindell (1992)
[10] Martínez-Taboas and Bernal (2000)
[11] McFarland and Alvaro (2000)
[12] Mezy (1888)
[13] Mikulincer et al. (1993)
[14] Nolen-Hoeksema and Davis (1999)
[15] Norris et al. (1997)
[16] Ozer et al. (2003)
[17] Resick et al. (2002)
[18] Stillwell and Baumeister (1997)
[19] Thompson (2000)
[20] Ullman (1999)
[21] Wolkenstein and Sterman (1998)

Updated references

[22] Daniels, Bradley and Hays (2007)
[23] Green and Diaz (2007)
[24] Green and Diaz (2008)
[25] Janoff (2005)
[26] Löbmann et al. (2003)
[27] Manktelow (2007)
[28] Nordanger (2007)
[29] Peleikis et al. (2004)
[30] Ystgaard et al. (2004.)

4.1 Positive Coping Strategies

Seeking information

Often, victims of crime simply want information (Hagemann 1992). Useful information might include details about the justice system, program options, and common reactions (Greenberg and Ruback 1992). Gathering information can also play a key part in the victim's decision between different treatment options or even whether to seek help at all (Prochaska et al. 1992).

Cognitive reframing of victimization: Self-comparison and emphasizing the positive aspects of having survived

In research on sexual assault victims, Hagemann (1992) noted that some victims feel better by focusing on how they are now survivors. Thompson (2000) noted that sexual assault victims may initially embrace the term "victim" because it shows that the assault was not their fault. As they deal with their experience, they switch to "survivor" because it reflects strength, recovery, and being a fighter. This seems to help some victims regain control over their lives. When dealing with tough situations, people often need to make sense of what happened and then search for some personal benefit, no matter how negative the event was (Davis et al. 1998).

Put into lay terms, this point means: "That which does not kill you makes you stronger." Getting through a difficult situation successfully seems to help victims see themselves as strong (Thompson 2000), and the tougher the situation the greater the effect (McFarland and Alvaro 2000). In fact, people will often see themselves as having been much weaker before the event, even if that is not true (McFarland and Alvaro 2000). This may be done in an effort to see benefit in an obviously difficult situation (Davis et al. 1998). Tugade and Fredrickson (2007) discuss how resilient people are able to find positive meanings in negative events.

Cognitive reframing of victimization: Social comparison

Victims will often compare themselves to other victims in an effort to make sense of what happened to them. They may look to victims who are doing well as an inspiration to keep going (Greenberg and Ruback 1992). This is a double-edged sword, as they may also lose hope if they feel they aren't making similar progress. Victims may also compare themselves to other victims who are worse off – they may feel better that they weren't victimized as badly as someone else (Hagemann 1992; Greenberg and Ruback 1992; Thompson 2000). If they don't know of others who are worse off, these victims will create fantasies of "it could have been much worse." In these fantasies, they review the crime but add in even greater physical, emotional or personal damage (Greenberg and Ruback 1992). This seems to help people gain perspective, and may even relate to a focus on the positive aspects of being a survivor (Thompson 2000).

Activities for regaining control

Victims can also do things that make them feel more in control of their life. For instance, victims of assault might take self-defence classes (Hagemann 1992), while other victims might lay charges and go to court (Greenberg and Ruback 1992).

Activism

It appears that some victims heal by becoming advocates or activists (Hagemann 1992). They apply their experience on a social level, trying to change society so that it will create fewer victims or treat victims more fairly.

Emotion-focused coping

Emotion-focused coping involves activities that try to directly change how the victim feels (positive thinking, relaxation, expression of emotions, distraction). Recent research suggests that emotion-focused coping may help to reduce stress and improve the victim's self-assessment of how he or she is coping (Green and Diaz 2007 and 2008). In contrast, these researchers found that problem-focused coping (strategies that focus on changing their actions in the situation) increased emotional distress. This link was stronger among women than men.

Use of social support

Crime victims often feel out of sorts (Casarez-Levison 1992) and may seek others for support (Greenberg and Beach 2004; Greenberg and Ruback 1992; Leymann and Lindell 1992; Norris et al. 1997; Steel et al. 2004). Research indicates that people who get positive social support show better adjustment (Nolen-Hoeksema and Davis 1999; Steel et al. 2004). Further, it appears that even the belief that they have support can make victims feel better (Green and Diaz 2007), especially if they are dealing with anger (Green and Pomeroy 2007). Both natural supports (family, friends, etc.) and professional supports (police, lawyer, clergy, medical, mental health) can offer help to the victim. Although the decision regarding where to go for support lies with the victim, those who use natural supports are also more likely to seek professional help, especially if they feel positively supported (Norris et al. 1997). Supportive people may provide information, companionship, reality checks, emotional support, and money or a safe place to live (Everly et al. 2000). Support also seems to reduce the victim's anxiety (Green and Pomeroy 2007). A recent Canadian survey indicates that 60% of victims of violent crime and 80% of victims of non-violent crime seek out family support (AuCoin and Beauchamp 2007).

Norris et al. (1997) noted that some victims benefit from talking to other people about their experience and feelings. Telling their story seems to help make sense of what happened and of their emotions (Greenberg and Ruback 1992). It may help them let go of troubling feelings or get a reality check about thoughts, actions and feelings (Greenberg and Ruback 1992; Leymann and Lindell 1992; Nolen-Hoeksema and Davis 1999; Norris et al. 1997). Victims are often able to

describe the type of support they want. The information in Table 4 will help workers think about support and match the victim's needs to which type of support to provide or access. We should be careful not to get caught up in providing the type of support we think victims need rather than asking them for guidance.

Table 4: Types of Support
(developed from Leymann and Lindell 1992).

Support Type	Description
Emotional	Esteem, concern and listening with a focus on the victim's feelings and reactions
Appraisal	Social comparison, affirmation and feedback targeted at helping the victim make sense of his or her experiences
Informational	Advice, suggestions, directives and information
Instrumental	Material support such as money, shelter, time or effort

Perceived support versus actual support

It is important for workers to realize that both actual support (e.g. going to a support group or meeting with a counsellor) and perceived support (e.g. believing help is available if it is needed) help victims cope. Perceived support results in reduced fear, depression and post-traumatic stress symptoms (Norris et al. 1997; Ozer et al. 2003; Steel et al. 2004). A possible explanation for this finding is that people need to know that they can get support if they want it and that others are concerned about them. In fact, a poor reaction from supports is linked with increased victim distress (Mueller et al. 2008). Just knowing that their local community has a victim services office may help many victims cope – even if they never use the services. Needless to say, receiving actual support is also helpful to victims (Norris et al. 1997; Ozer et al. 2003).

Professional supports versus natural supports

Some victims report that they find their natural supports more useful than professional support (Leymann and Lindell 1992); however, in some cases, they may still prefer to rely upon professionals. Recent research with victims of family violence shows that women dealing

with "intimate terrorism" (ongoing violence based on power and control) were more likely to access professional supports than woman dealing with partner violence over specific conflicts (Leahy et al. 2004). Other research indicates that cultural attitudes about victimization (e.g. shame associated with being a victim of sexual assault) may influence choices in seeking out professional or natural supports (Yamawaki 2007). It is likely that the victim decides on the best source for support based upon her attitudes, expectations, needs and past experience.

Workers and victims should be aware that those in the victim's natural support system might be less able to deal with the challenges facing the victim. Natural supports may initially be helpful, but they can make mistakes or become overwhelmed with the intensity of helping the victim cope (Mikulincer et al. 1993; Nolen-Hoeksema and Davis 1999). A recent survey examining crime victimization and PTSD showed that natural supports were not as helpful to people who had high levels of repeated victimization (Scarpa et al. 2006). In the worst case, the natural supports may not believe the victim or have a negative reaction, causing even more distress (Leahy et al. 2003; Mueller et al. 2008). Some victims describe feeling that their normal supports begin to avoid contact because they do not know what to do (DeValve 2005). In any case, a social network can "burn out" leaving the victim feeling abandoned, isolated and misunderstood.

Look back at Table 4 and imagine a friend trying to be emotionally supportive when the victim only wants information. This mismatch could result in his not going to that friend (or others) again because he feels frustrated and misunderstood. Each person has his or her own way of coping with victimization. If we try to get others to adopt our style of coping, they may feel that they have not been heard (Nelson et al. 2002). This is important because dealing with non-supportive people can add new layers of stress onto an already tough situation (Nolen-Hoeksema and Davis 1999).

For these reasons, some victims may find it helpful to seek out professional support. In an ideal world, most professionals would have training in listening, empathy, challenging, and providing a range of therapeutic actions. Professionals should be better equipped to cope with repetitive stories and accounts. They should also be better able to identify and provide the specific support needed by the victim. Furthermore, with a professional, victims do not need to be concerned about damaging a personal bond, since the relationship is focused on

dealing with the crime-related trauma. Professionals should also be less likely to impose their views and work to meet the victim "where he or she lives." Some researchers have warned that professionals and paraprofessionals with their own victimization histories may "over-promote" certain solutions because they worked for them (Salston and Figley 2003).

4.2 Negative Coping Strategies

Active behavioural avoidance

Avoidance can show up as behavioural avoidance, such as not leaving one's apartment or taking time off work (Hagemann 1992), avoiding victim services workers or therapists (Gorde et al. 2004), and so forth. Generally speaking, researchers agree that avoidance is at best a band-aid solution and at worst ineffective and harmful (Scarpa et al. 2006). Research on female victims of assault (sexual or physical) found that those who knew their assailant and also withdrew from supports in the initial aftermath of the crime were at increased risk of developing PTSD (Gutner et al. 2006). This means that those victims who initially avoid social contacts may have increased problems (see benefits of social support above). In examining survivors of family violence, researchers found that avoiding help may be related to the stability of their living arrangements: victims in shelters or transition housing were more likely to use avoidance than those in the community (Gorde et al. 2004).

In some cases, initial avoidance of challenging situations may help victims slowly build on small successes. This may allow victims to take time to heal and gather resources to rebuild their lives and deal with other challenges (e. g. the criminal justice system). As they receive treatment focused on confronting their fear, they are likely to feel better.

Denial and self-deception

Acting as a type of psychological avoidance, denial and self-deception work to help victims temporarily erase the memories. Thompson (2000) discusses the active blocking of memories and feelings to help cope with overwhelming emotions. Stillwell and Baumeister (1997) indicate that people tend to bias their recall to make themselves appear more sympathetic. In researching trauma associated with living in a war zone, Mikulincer et al. (1993) found that people who

cope by avoiding are more likely to deny or minimize their internal distress. Although these approaches may get in the way of seeking help, they may also lessen initial distress (Hagemann 1992). Ullman (1999) agrees, and indicated that although avoidance strategies are usually linked to greater problems, they could also be adaptive by helping the victim get through the initial trauma.

Dissociation

Dissociation is a clinical term that means that there is a break in a person's normal way of thinking, memory, identity or how he sees his environment. This is similar to what most people might call "shock". Although we all dissociate to some degree, people with a history of frequent and severe traumatic experiences seem more commonly to use it to cope (Martínez-Taboas and Bernal 2000). Workers need to remember that dissociation can be a natural way of dealing with trauma. Harvey and Bryant (2002) indicated that dissociation might help a victim cope with the initial trauma by getting in the way of recording memories during the crime. This cognitive change allows the victim to forget difficult elements of the crime or trauma and may result in reduced distress. However, mounting evidence around initial dissociation and subsequent problems is casting doubt on this theory (Bromberg 2003; Elklit and Brink 2004; Halligan et al. 2003; Ozer et al. (2003).

Dissociation can also be a negative coping strategy when used for too long. Halligan et al. (2003) indicated that specific elements of dissociation, namely emotional numbing, confusion or altered sense of time, and moodiness or impulsiveness, were more related to PTSD. They found that emotional numbing and confusion likely interfered most with dealing with the trauma. Elklit and Brink (2004) found that initial shock, dissociation, and numbing were related to the PTSD that followed six months later. Ozer et al. (2003) found that those who experience dissociation either during or immediately after a traumatic experience were more likely to develop PTSD; this link was most evident in those who later wanted mental health services. Further, others have noted that prolonged dissociation can interfere with the healing process or treatment (Bromberg 2003). Thus, dissociation is a double-edged sword; it may help in the short term, but it seems to place the victim at increased risk for later problems.

Substance misuse

Misuse or abuse of alcohol or drugs (self-medication through illegal drugs or overuse of prescription medication) is often mentioned in the literature as a complicating factor in victims of crime (Casarez-Levison 1992; Everly et al. 2000; Hagemann 1992; Mezy 1988; Wolkenstein and Sterman 1998). Those who self-medicate to avoid their pain, etc. are likely to experience even greater challenges, since using alcohol or drugs can often interfere with decision making and coping (Kilpatrick et al. 2003). A study of victimization of adolescent girls and alcohol use showed that early initiation into drinking and binge drinking increased the chance of victimization (Champion et al. 2004). They also point out that those who abuse substances might be at increased risk for victimization. Specifically, people abusing substances may put themselves in unsafe situations, have poor ability to assess dangerous situations or people, and be more vulnerable to victimizers. Thus, substance misuse might be a coping strategy that increases the chance of future victimization (Champion et al. 2004). Morrison and Doucet (2008) recently completed a review of the literature on crime victimization and substance misuse, noting the importance of training, screening, improved case management and treatment strategies to improve working with this group.

Confrontation: Cognitively narrowing the focus

Holman and Silver (1998) pointed out that when people are presented with complex stimuli, their ability to process the information is weakened. Thus, they may slow down time in their heads to cope with everything that is going on. These authors point out that this should help them adapt, but some people become overly focused on the traumatic event, ignoring everything else (Holman and Silver 1998). This change in consciousness is similar to dissociation (Bromberg 2003), but the focus is on trying to deal with the stressor rather than ignoring it. Further, Greenberg and Ruback (1992) found that arousal, specifically anger, resulted in improved recall. Thus, focused arousal may allow the victim to pay closer attention to the specifics of the crime. However, recent research supports the conclusion that this focus can cause problems for a person trying to move beyond the victimization experience because they are unable to focus on other aspects of his life (Orth et al. 2008; Orth et al. 2006).

Deliberate (Non-Suicidal) Self-harm

Deliberate self-harm or non-suicidal self-harm is when a person deliberately causes themself harm. Although one often hears of people engaging in physical self-harm such as cutting or burning themselves, there is an argument that self-destructive behaviours such as prostitution, substance abuse, eating disorders and so forth also fall under the category of deliberate self-harm (Cyr et al. 2005; Dell 2008). In a study of women undergoing treatment for anxiety and depression, Peleikis et al. (2004) noted that having a history of childhood sexual abuse placed women at increased risk for self-harm. A Quebec study of female adolescents who were victims of sexual abuse showed that 62.1% had engaged in self-mutilation (Cyr et al. 2005). These researchers also found that those in the high self-harm group reported more problems with depression and dissociation. Research on female psychiatric patients showed a relationship between domestic violence and self-harm behaviours, indicating that it may be important to screen for this issue among these victims (Sansone et al. 2007).

Workers should also note that such self-harm is not a suicide attempt, but rather a behaviour focused on reducing emotional distress (Dell 2008). However, much confusion occurs because non-suicidal self-harm can be mistaken for suicidal behaviour (Dell 2008). In a study examining histories of abuse in people who truly wanted to kill themselves, those who had repeated attempts and reported childhood sexual or physical abuse also reported higher levels of self-harm behaviour (Ystgaard et al. 2004).

4.3 Resiliency, Self-efficacy and Post-traumatic Growth

In examining coping strategies in victims of crime there is growing research that examines how people successfully weather challenges. Resiliency, self-efficacy and post-traumatic growth are three slightly different ways of looking at how people can apply strengths to dealing with trauma. Workers may be interested in these concepts as ways to improve their understanding of how people can move forward.

Resilience refers to a person's ability to maintain a balanced state in the face of challenges (Bonanno 2004). It is not simply the absence of problems, but the ability to remain unaffected and actually stay healthy despite challenges. It is also not the same as recovery, which has an element of "bouncing back" after being traumatized (Bonanno

2005). Resilience is common (Bonanno 2004; Westphal and Bonanno 2007); as noted above, most people faced with criminal victimization do not go on to develop mental health problems (Ozer et al. 2003).

Truly resilient clients will be a rarity in clinical practice, but may appear on workers' caseloads as they are preparing to testify in court. These victims may still need a range of support, but they are likely to present and handle the stress well. In clinical practice, it is more likely that workers will find themselves dealing with issues relating to self-efficacy and post-traumatic growth.

Self-efficacy refers to a person's belief that he or she has the tools and resources to successfully handle a challenge or task (Bandura 1997). Researchers have identified self-efficacy as a characteristic similar to resilience that may make people less likely to develop a severe reaction to being victimized (Thompson, et al. 2002). Self-efficacy is a merging of self-esteem with a belief that you can affect your environment. Thompson et al. (2002) noted that helping women develop high levels of self-efficacy about life skills might increase the chance they would leave their violent relationship. This challenges the "isolation" factor that one often sees in domestic violence.

Each victim has a different level of self-efficacy prior to the crime. Over a lifetime, individuals who experience successes will increase self-efficacy and confidence. Contrast this to a lifetime of experiencing an inability to cope, which decreases an individual's self-efficacy. These previous levels of self-efficacy, in combination with the impact of the crime, will affect how the victim copes. For example, those who feel that they will receive help if they ask often feel better (Mikulincer et al. 1993). Thus, self-efficacy can play a central role in coping with trauma and seeking help. Also, these individuals may have greater coping skills to help them. Other victims may need to develop skills and build up self-efficacy to deal with stress. Many effective treatments for victims include activities that require them to confront and successfully deal with difficult memories and emotions or learn and practise new skills, which ultimately increases the sense of self-efficacy (Amstadter et al. 2007; Nishith et al. 2002; Resick et al. 2002).

"Post-traumatic growth" (PTG) refers to situations where a person who has been affected by the trauma learns new coping strategies or gains a new perspective by facing the problem. Overly resilient people may miss this growth opportunity since they are unaffected by the challenge (Pat-Horenczyk and Brom 2007; Tedeschi and Calhoun 2004).

It is important to note that PTG does not mean that dealing with trauma is a positive experience in these people's lives. Even those people who report high levels of PTG also indicate many problems and difficulties related to the trauma (Calhoun and Tedeschi 2006). In other words, most people would rather have avoided the trauma altogether, but are able to recognize how they have grown.

When considering PTG, it may be useful to examine the different types of PTG that victims may experience. Calhoun and Tedeschi (2006) looked at PTG statistically and found three general categories of growth:

1) Change in how the person sees herself or himself
   a) Personal strength: I can survive anything
   b) New possibilities: I want to explore new interests/ activities
2) Change in how he or she relates to others: Connection and compassion
3) Change in life philosophy
   a) Appreciation of life (enjoy the little things)
   b) Spiritual change

Workers may be able to identify growth processes within specific clients or within all their clients. Those victims with few skills and resources are likely to become quickly overwhelmed by trauma. Much work will be needed for the person to face the challenges brought about by the crime. Many people will have some skills to face problems but will also need to build new ones (PTG). Finally, some people are at the extreme and will be unaffected by trauma (resilient). Much research shows that victims are initially affected but that they use their personal and social resources (self-efficacy) to "bounce back" – this is PTG.

Workers may want to take a broader view of resiliency and incorporate the PTG perspective that many victims are, in fact, affected by the criminal victimization but are able nonetheless to rebuild their lives and potentially learn new ways of coping. Given this, what are some of the key research findings around resiliency and how can workers encourage growth and resiliency in their clients? Bonanno (2005) indicates that many of the activities we would identify as healthy living (personal resources, a good support network, pragmatism) also promote resilience. Researchers have identified several factors related to successfully facing challenges:

Hardiness/Autonomy/Self-confidence (Bonanno 2004; Bondy et al. 2007; Haskett et al. 2006; Williams 2007) refers to having the skills and abilities to create a life that you want. Bonanno (2004) notes that hardiness is made up of three elements: 1) finding meaningful purpose in life, 2) the belief that one can influence the environment and event, and 3) the belief that positive and negative life experiences are growth opportunities. Workers will note that the last two elements are very similar to the concept of self-efficacy and incorporate elements of PTG.

Positive personal identity can help a person remain centred in the face of challenges. People who have a realistically positive view of themselves are likely to have the strength to deal with problems. Others may have an unrealistic or overly positive view of themselves – a type of overconfidence called "self-enhancement" (Bonanno 2004; Bonanno 2005) that helps them withstand challenges. Associates may not like them and may even view them as narcissistic, but self-enhancers tend to deal with loss more effectively than the general population.

Adaptability (Bonanno 2005) in adjusting to life's challenges also helps people cope with challenges and adjust better over the long term. This may be emotional or behavioural adaptability (Bonanno 2005) or finding the positive meaning in negative events ("silver lining"; Tugade, and Fredrickson 2007).

Positive outlook in the form of hope for the future helps make people more resilient (Bondy et al. 2007). Similarly, resilient people tend to see the world as a safe place (Williams 2007). Workers can recognize that many victims struggle with keeping this positive outlook in the face of criminal victimization. In fact, much effort goes into building hope and motivation when supporting victims of crime.

Repressive copers (Bonanno 2004) are people who tend to avoid negative thoughts, emotions and memories. Research shows that repressive copers tend to emotionally disengage from challenging situations in that they report that they do not feel stress even when physical measures indicate that they are stressed. It appears this disengagement increases their resiliency.

Experiencing and managing complex emotions (Coifman et al. 2007; Haskett et al. 2006) helps people effectively face challenging situations and not feel overwhelmed. Workers may recall certain victims who seem able to handle emotions (not avoid them!) and keep emotionally calm when dealing with the challenge of the victimization and the justice system.

Experiencing positive emotions (Bonanno 2005; Tugade and Fredrickson 2007) helps people by not simply replacing negative emotions but by countering their effects as well (Bonanno 2004). There is theory and research that concludes that positive emotions improve creativity and problem-solving (Fredrickson 1998). Furthermore, Bonanno (2005) points out that others may be more supportive to people who express positive emotions, thus increasing support to the person. Fredrickson et al. (2003) noted that positive emotions such as gratitude, interest and love helped people cope after the 9/11 attack and avoid depression.

Social support (Bonanno 2005; Gewirtz and Edleson 2007; Haskett et al. 2006; Sun and Hui 2007; Williams 2007) and having high-quality relationships with family or peer group seems to bode well for weathering challenges. As noted in more detail earlier, workers will want to pay attention to the victim's natural supports and may even want to educate natural supports about victimization.

Social competence (Bondy et al. 2007; Gewirtz and Edleson 2007; Haskett et al. 2006) relates to the person's skills in communication, empathy and caring, and the capacity to positively connect to others. This likely improves resiliency by helping the person successfully meet needs and likely increases the size and quality of the support network.

Cognitive skills (Bondy et al. 2007; Gewirtz and Edleson 2007; Haskett et al. 2006; Williams 2007) such as intelligence, effective problem solving and planning skills are also related to being successful in facing challenges.

To increase resiliency, self-efficacy and the possibility of PTG, victims need to build on resources. Victims can build on strengths and learn to identify the positives, enjoy good days or positive supports, learn to relax and consider blessings or even make sure that they take time to

truly savour a compliment. Workers can support these healthy choices. This is not to say these will be easy steps, especially with victims dealing with grief and loss. By practising strength-building activities, victims of crime will become primed to the habit of effectively dealing with setbacks (Tugade and Fredrickson 2007).

4.4 The Basics

Coping

- When victims' lives are upset by a crime, they will try to cope in the best way they know how.
- Coping strategies can be divided into positive strategies and negative strategies. Using negative strategies can make the victim feel worse (Dempsey 2002).
- Table 3 lists the different coping strategies often used by victims.

Table 3: Common Coping Strategies

Positive Coping Strategies	Negative Coping Strategies
Information seeking [5]	Avoiding reminders of the crime [2, 5, 13, 20, 21, 22, 25, 26, 27, 28]
Self-comparison/emphasizing the positive aspects of surviving [1, 5, 11, 19]	Behavioural avoidance - Use of drugs/alcohol
Social comparison [4, 5, 8, 19]	Denial and self-deception [13, 18, 19, 20, 26]
Activities to regain control [4, 5, 26]	Dissociation [6, 10, 15]
Activism [5]	Obsessing about the crime [4, 7]
Time to heal [3, 5, 15, 17]	Self-harm [29, 30]
Emotion-focused coping [23, 24]	
Getting support [2, 4, 9, 14, 15, 23, 24]	

Table 3: Common Coping Strategies, (*cont)*

[1] Davis et al. (1998)
[2] Everly et al. (2000)
[3] Gilboa-Schechtman and Foa (2001)
[4] Greenberg and Ruback (1992)
[5] Hagemann (1992)
[6] Harvey and Bryant (2002)
[7] Holman and Silver (1998)
[8] Layne et al. (2001)
[9] Leymann and Lindell (1992)
[10] Martínez-Taboas and Bernal (2000)
[11] McFarland and Alvaro (2000)
[12] Mezy (1888)
[13] Mikulincer et al. (1993)
[14] Nolen-Hoeksema and Davis (1999)
[15] Norris et al. (1997)
[16] Ozer et al. (2003)
[17] Resick et al. (2002)
[18] Stillwell and Baumeister (1997)
[19] Thompson (2000)
[20] Ullman (1999)
[21] Wolkenstein and Sterman (1998)

Updated references

[22] Daniels, Bradley and Hays (2007)
[23] Green and Diaz (2007)
[24] Green and Diaz (2008)
[25] Janoff (2005)
[26] Löbmann et al. (2003)
[27] Manktelow (2007)
[28] Nordanger (2007)
[29] Peleikis et al. (2004)
[30] Ystgaard et al. (2004.)

Positive coping: social support

- Social support is very important for many victims as they try to make sense of their victimization (Greenberg and Ruback 1992; Leymann and Lindell 1992; Norris et al. 1997).
- Victims find support from their family and friends more useful than support from professionals (Leymann and Lindell 1992).
- Victims need to known that support is available, even if they do not access it (Norris et al. 1997; Ozer et al. 2003).
- Supports can be a key source of information (Hagemann 1992).
- Emotion focused coping may decrease distress (Green and Diaz 2007 and 2008).
- Professional supports could be important when family and friends are overwhelmed (Mikulincer et al. 1993; Nolen-Hoeksema and Davis 1999).

Negative coping: avoidance

- Avoidance, either through drugs, avoiding locations, denial or dissociation is a common way victims cope with overwhelming emotions (Bromberg 2003; Everly et al. 2000; Hagemann 1992; Mezy 1988; Thompson 2000; Wolkenstein and Sterman 1998).
- Although avoidance may help the victim deal with initial distress (Hagemann 1992; Harvey and Bryant 2002; Ullman 1999), it is linked to long-term problems (Bromberg 2003; Halligan et al. 2003; Ozer et al. 2003; Ullman 1999).
- Avoidance through the use of drugs and alcohol can interfere with decision-making and problem-solving, which creates even greater challenges to positive healing.

Resiliency, self-efficacy and post-traumatic growth

- Resilience refers to a person's ability to maintain a balanced state in the face of challenges (Bonanno 2004).
- Resilience is common (Bonanno 2004; Westphal and Bonanno 2007).
- Self-efficacy refers to the belief a person has the tools and resources to successfully handle a challenge or task (Bandura 1997).
- Self-efficacy is a merging of self-esteem with a belief that you can affect your environment.
- High self-efficacy may reduce the chances that a victim will have a negative reaction to trauma (Thompson et al. 2002).
- Self-efficacy can affect coping choices by people picking those coping strategies that they feel will succeed (Bandura 1997).
- Successful treatment programs include elements of building self-efficacy to help victims (Nishith et al. 2002; Resick et al. 2002).
- Post-traumatic growth (PTG) refers to when a person is affected by the trauma and learns new coping strategies or gains a new perspective by facing the problem. It is important to note that PTG does not mean that dealing with trauma is a positive experience in these people's lives.
- PTG can be seen in how a person sees himself or herself (personal strength; new possibilities), and relates to others and his or her life philosophy (appreciation; spiritual) (Calhoun and Tedeschi 2006).

- Characteristics associated with resilience and growth include:
  a) Hardiness/autonomy/self-confidence (Bonanno 2004; Bondy et al. 2007; Haskett et al. 2006; Williams 2007).
  b) Having a positive personal identity.
  c) Being adaptable (Bonanno 2005; Tugade, and Fredrickson 2007).
  d) Having a positive outlook (Bondy et al. 2007; Williams 2007).
  e) Being a repressive coper ---people who tend to avoid negative thoughts, emotions and memories (Bonanno 2004).
  f) Experiencing and managing complex emotions (Coifman et al. 2007; Haskett et al. 2006).
  g) Experiencing positive emotions (Bonanno 2004 and 2005; Fredrickson 1998; Tugade and Fredrickson 2007).
  h) Having social support (Bonanno 2005; Gewirtz, and Edleson 2007; Haskett et al. 2006; Sun and Hui 2007; Williams 2007).
  i) Having social competence (Bondy et al. 2007; Gewirtz, and Edleson 2007; Haskett et al. 2006).
  j) Cognitive skills (Bondy et al. 2007; Gewirtz, and Edleson 2007; Haskett et al. 2006; Williams 2007).

- Exceptionally resilient people may miss this growth opportunity since they are, by definition, essentially unaffected by the crime (Pat-Horenczyk and Brom 2007; Tedeschi and Calhoun 2004).

5.0 A Model For Client Change: The Stages of Change

Workers often face the problem of how best to help clients cope with trauma. Crime victims can be a particular challenge because of the depth of their issues and the fact that, like many clients, progress is often accompanied by periods of no movement and backsliding. Prochaska et al. (1992) developed a model to try to understand how people change, both in treatment and on their own; they called it the Transtheoretical Model of Change (TMC). They found that people cycle through different stages: precontemplation (no plan to change because they don't believe they have a problem), contemplation (aware of the problem and seriously considering change), preparation (intend to do something soon), action (actively trying to make change) and maintenance (keeping the gains). Although people speak of stages, workers need to understand that a person can exist at all stages at the same time, and shift depending on the specific issue being discussed (Prochaska et al. 1992).

5.1 How The Stages Work

Although little work has been done linking these stages to crime victims, this model may be useful to workers in understanding those requesting services. There is some limited research on female victims of family violence and the process they use to decide whether to remain in the relationship (Cluss et al. 2006; Shurman and Rodriguez 2006). With respect to help-seeking in victims, one study looked at adult survivors of childhood sexual abuse receiving therapy (Koraleski and Larson 1997). Out of 83 people in therapy they identified 38 (45.8%) as mostly being in the contemplation stage, 7 (8.4%) as in the preparation stage, and 26 (31.3%) as in the action stage. This is often the case – people will enter treatment without being sure if they want to change. Victims may recognize they have a problem resulting from victimization and may seek out therapy to deal with depression or anxiety (action). However, they may refuse to talk about the crime itself, saying that it has nothing to do with the depression (precontemplation). They might then drop out of therapy but still recognize that they needs help (contemplation).

Table 5: The Transtheoretical Model of Change (Prochaska et al. 1992)

Precontemplation	Contemplation	Preparation	Action	Maintenance
These people have no intention of changing. They are often unaware of any problems or deny the extent or severity of the problem. Often, they focus on the negatives of changing and only come in because others have pushed them to seek help. Workers might meet victims who deny problems or trauma but loved ones describe changes in the victim's mood, behaviour or overall health. In fact, certain crime victims may deny that there was even a crime (e.g. victims of date rape).	These people are aware of their problem and are seriously considering making a change but are not doing anything to change. They can often spend much time struggling with staying the same versus the amount of effort, energy, and loss it will cost them to overcome the problem. Workers might have clients who agree they need help but are frozen by shame, fear of telling someone, fear of reactions, or fear that talking about it might make things worse.	People in this stage recognize the problem and plan to do something in a very brief time. In examining habit change, these individuals have often tried to make changes in the past year, but have failed to make lasting changes. Workers identify this group by noting those who have made some changes on their own and are waiting for an appointment or have tried therapy. This stage is usually very short as the person prepares for change efforts.	People in this stage are actively trying to make changes to improve their situation. Workers will recognize this as active treatment. Often family and other supports see this as "real" effort and change. Usually this stage is linked to reaching a certain goal. Traditional treatment efforts tends to focus on this stage, ignoring the work the victim must do in deciding to seek help. It also ignores the work that follows treatment in staying healthy.	People in the maintenance stage work to keep the gains made during the action stage. Maintenance is not a static stage, but the process of change. Workers can help victims by teaching them to talk to supports about stress, watch their own behaviour, thoughts and emotions, and develop skills that might reduce the chances they will be revictimized.

For these reasons, is it important that workers assess where victims are in relation to an issue, and not assume just because they asked for help that they are ready for intensive treatment. In fact, this may overwhelm the victim and cause more distress. If we push too much it may result in victims feeling attacked and increase the likelihood that they will quit and not receive the help they need.

The biggest leap for clients happens as they move from the precontemplation stage to the three stages that follow (Rosen 2000). Further, so-called precontemplators report more distress with treatment, less progress and are more likely to quit treatment early (Smith et al. 1995). Workers need to be aware of this group because they inappropriately sit on waiting lists, miss appointments and do not take full advantage of therapy. This is not surprising, given that they are not ready to deal with their problems. Thus, it is important to motivate all clients to get the most out of therapy and use resources (both personal and financial) wisely.

5.2 Adjusting Your Approach To Fit The Client

How you work with clients is quite individual. It depends on your goals, your training and your own personal style. However, the TMC model has some suggestions regarding how best to help clients. We train for clients who are in the action stage, ready to make changes; they tend to be motivated and ready to work on their issues. Most workers would want a caseload filled with this group! However, as noted above, not all people who come to your office will be this motivated.

Those people primarily in the precontemplation and contemplation stages can also benefit from interventions, but these may be different from what workers normally think about as treatment. Workers can offer those in the precontemplation stage reading material such as brochures about common reactions or self-help books. The worker can also spend time with this group to teach them about victimization/trauma and so on. These clients may not recognize that their symptoms are related to the crime or even that they have changed. Keep in mind that precontemplators often show up in our offices because others have sent them. "Consciousness-raising" activities not only help victims to learn about possible reactions, but these strategies also help them recognize the value of doing something

about these negative symptoms or feelings (Prochaska et al. 1994). You must be careful not to pressure the victim and to work with areas of health so that the victim can make a decision that works for him or her (Frasier et al. 2001).

Rosen (2000) noted that precontemplators and contemplators can be motivated to seek help by gathering information (consciousness raising), looking at the effects on themselves (self re-evaluation) and others (environmental re-evaluation), experiencing and expressing emotions (dramatic relief), and monitoring changing social norms (social liberation). Workers can help those in these two stages by helping them to look at the costs of staying the way they are and the benefits of getting help. Safety planning may be important, depending on the victims' decisions (Frasier et al. 2001). Keep in mind that most of the change that people undergo happens between precontemplation and contemplation (Rosen 2000). However, any efforts towards helping victims to build and keep motivation can be key in helping them to get the full benefit of treatment. Making progress and feeling better motivate clients.

These activities may help victims take the big step of deciding they need help, or help them to address particularly painful problems. Further, these interventions can be useful for all clients. Imagine a female victim of family violence who is feeling better and whose husband is treating her well ("honeymoon phase") and promises never to hurt her again. He puts pressure on her, saying that she keeps going to her therapy group because she doesn't believe in him. This victim will need support because she now has to work to believe that there are benefits to staying in therapy – her problem has been solved! Workers therefore need to understand the victim's thinking and beliefs about what makes up "improvement." Workers can help her explore the cycle of abuse, the possibility of "honeymoon" periods and the long-term benefits of treatment so that she can make the best decision for herself. In a sense, this is allowing your client to have as much information as possible to make a good decision about what she needs to do to improve her life.

Once your clients have reached their goals, they move into the maintenance stage. In a sense this is what Casarez-Levison (1992) describes as the Reorganization/ Resolution stage of dealing with victimization. Workers can help victims prepare for this stage by teaching them about healthy living skills. Victims need to learn to watch for warning signs

that they are backsliding. Also, workers need to spend some time during treatment teaching their clients specific skills and strategies that allow them to practise those skills effectively. These relapse-prevention strategies will help clients monitor themselves and their world. For example, a man who was assaulted in an underground parking garage is forewarned that this may be a challenging place for him. If he decides to park in an underground garage, he can prepare for increased distress or related symptoms. By teaching him skills, the worker helps him not to avoid these situations but rather to gain control over his thoughts and feelings so that he can have confidence when facing challenging situations (self-efficacy).

Truly challenging cases are best left to trained clinicians; however, all workers benefit from understanding that change is a process and that the victim is not intentionally trying to be difficult. The TMC basically challenges old concepts of "resistance" by focusing on shifting our clinical approach (Prochaska et al. 1992). Seeking help can be difficult when you feel you are delicately balanced. Mitchell (1993) notes that many clients (not just victims) come into therapy hoping to get help but fearing that the change will be too painful or change their life too much.

One final note: all of these techniques can be used to motivate and teach the victim's natural support system (family and friends). Thus, a brochure about common reactions to crime victimization left on a coffee table can help a client in his or her home life. Victims can also teach their support system about these issues, helping supports understand but also gaining more control and self-efficacy by being able to educate others.

5.3 The Basics

- In trying to change, people cycle through different stages: precontemplation (no plan to change because they don't believe they have a problem), contemplation (aware of the problem and are seriously considering change), preparation (intend to do something soon), action (actively trying to make change) and maintenance (keeping the gains) (Prochaska et al. 1992).

- People may be mostly in one stage, but can be in all stages at the same time (Prochaska et al. 1992). For example, a victim may recognize she has a problem resulting from victimization and may seek out therapy to deal with depression or anxiety (action). However, she may refuse to talk about the crime itself, saying that it has nothing to do with the depression (precontemplation). She might then drop out of therapy but still recognize that she needs help (contemplation).
- People who feel they don't have a problem (precontemplators) report more distress with treatment, less progress and are more likely to quit treatment early (Smith et al. 1995).
- Most change happens when a person moves from precontemplation into the other three stages (Rosen 2000).
- Workers can decrease their own frustration and improve the effectiveness for victims by assessing where people are in these stages and selecting appropriate interventions.
- Precontemplators should be given "consciousness-raising" activities (reading, self-help books, attending information sessions, etc.). These efforts help the victim learn about possible reactions and the benefits of getting help (Prochaska et al. 1994).
- Other activities that can help motivate victims include looking at the effects on themselves and others, experiencing and expressing emotions, and paying attention to changing social norms regarding victimization and getting help (Rosen 2000).
- Workers can help victims prepare for leaving active treatment by: teaching them healthy living skills, educating them about early warning signs of backsliding, and helping them develop self-monitoring skills and other daily activities that are focused on gaining and maintaining control over their life. Allowing time for practising and mastering these skills is time well spent in treatment.
- Victims can also benefit by workers developing ways to help educate the victim's natural supports (family, friends, etc.)

6.0 Assessment Issues: What should I ask about?

6.1 Key Areas To Cover In An Initial Interview

One of the more important functions of a service-delivery model is the identification of client needs and linking the client to services. Based on the above research and theory, the following issues are highlighted as major areas of inquiry in the first few meetings with a client. However, gathering this information should be balanced with allowing victims a chance to talk about their own issues (Robinson 2000). In other words, workers would be well served by keeping the following issues in mind as they talk to a victim while allowing the victim to tell his or her story in their own words. This list is not a checklist, but a guide for informed clinical judgement.

Victim characteristics: history

- Previous victimization (childhood physical/sexual/emotional abuse)
- Previous victimization (other)
- Personal psychiatric history
- Family psychiatric history
- Previous PTSD, including severity
- Coping skills used in the past

Victim characteristics: current

- Personality characteristics
- Demographics
- Current coping strategies
- Use of alcohol/drugs
- Suicidality/ Homicidality/Retaliation assessment
- Self-harm assessment
- Current mental status: psychological disorders, coping, strengths, etc.
- Presence of dissociation
- Primary location in the Transtheoretical Model
- Victims' perception of what they need

Crime-related characteristics

- Specifics of the criminal event
- Severity of the crime
- Use of credible threat
- Use of weapon
- Single incident or chronic victimization
- Victim-perpetrator contact
- Known perpetrator
- Reaction of support system
- Reaction of professionals (secondary victimization)
- Extreme emotional or dissociative reaction to criminal event

Strengths and resources (Hill 2008)

- Positive coping skills used in the past
- Current coping strategies
- Identification of motivators
- Insight into challenges ahead
- Victim's strengths list
- Positive self-view
- Key skill areas
- Problem-solving skills
- Ability to manage emotions
- Ability to experience positive emotions
- Victim's support network or situation
- Communication skills
- Cognitive ability
- Rating of self-efficacy and resiliency

A "one-size-fits-all-service" does not work efficiently. Matching clients to a service within a continuum will benefit the most clients. As victims show increased distress and symptoms, they may need more intensive services. Thus, a victim who is not having a severe reaction may not need to join a support group or receive individual therapy. However, he or she might benefit from information sessions or written literature. Understanding how victims access supports and use their strengths is important in matching them to services. Those clients with more severe reactions and fewer resources may need more intensive therapy or even in-patient treatment.

7.0 Pulling it Together: Concluding Remarks

Crime victims deserve timely, effective interventions that help them cope with their victimization and return to the best level of functioning possible. This manual is designed to provide recent research information to help workers develop and deliver services. Those who deliver front-line services to crime victims often face people dealing with extreme distress, who have poor coping skills, mental health issues, little social support, who may have experienced repeated victimization and so forth. Basically, victims are a diverse group who have diverse reactions and require diverse services. It is important to note that all workers in victim services are dealing with these complex issues, from reception staff dealing with walk-in visits and telephone calls to those workers conducting groups and individual interventions. All these people can benefit from the information in this manual.

All workers should spend some time and effort in identifying and practising self-care activities. These skills will help them take care of themselves, their clients and their colleagues. Workers must be in their best mental state to help victims make decisions, learn new coping strategies, address supports, and build motivation. Further, workers can use the above research and theoretical information to help understand likely victim reactions and to improve intervention planning. By being forewarned, workers can adjust their interventions to the specific needs of each client. Such adjustments are central to bringing clients the best service possible. Workers should also note that the information and skills discussed above may help others affected by crime, such as a victim's natural support system. Workers are likely very familiar with working with the victim's supports in ensuring a healthy environment for the victim.

7.1 Key Research Points

As noted above, one goal of this manual is to give workers a reference to key research findings and to make links to helping victims. This section summarizes much of the above research for quick reference. By using Casarez-Levison's (1992) model to anchor key research findings, readers may gain insight into what faces the crime victim coping with victimization and recovery. Workers may want to keep the following issues in mind when working with victims and their supports.

Previctimization/Organization

This stage focuses on the previctimization adaptation level of the person (Casarez-Levison 1992). Here workers will want to gather a relatively comprehensive history, either through a formal interview or through their normal ways of gathering information. The following elements should be covered:

- History of childhood physical and sexual abuse (Hembree et al. 2004; Messman and Long 1996; Nishith et al. 2000; Pimlott-Kubiak and Cortina 2003; Young et al. 2007)
- History of previous post-traumatic stress disorder (PTSD) (Brunet et al. 2001)
- Severity of previous PTSD episode(s) (Brunet et al. 2001)
- History of previous crime victimization or trauma (Amstadter et al. 2007; Byrne et al. 1999; Messman and Long 1996; Nishith et al. 2000; Norris et al. 1997; Ozer et al. 2003)
- Psychiatric history, especially depression (Boccellari, et al. 2007; Ozer et al. 2003)
- Family history of psychiatric problems (Ozer et al. 2003)
- Personality characteristics (Davis et al. 1998; Nolen-Hoeksema and Davis 1999; Thompson et al. 2002)
- Coping history (Dempsey 2002; Everly et al. 2000; Harvey and Bryant 2002)
- An inventory of strength and resources (Bandura 1997; Bonanno 2004; Bonanno 2005; Tedeschi and Calhoun 2004)
- Interpersonal relationship history (Kliewer et al. 2001; Mikulincer et al. 1993; Nelson et al. 2002)

Victimization/Disorganization

- Crime characteristics, especially severity, have a profound effect on trauma (Gilboa-Schechtman and Foa 2001; Hembree et al. 2004; Norris et al. 1997; Ozer et al. 2003).
- Characteristics such as gender, age, culture, and history can affect the victim's reaction (Boccellari et al. 2007; Brewin et al. 2000, Greenberg and Ruback 1992; Gabriel et al. 2007; Pimlott-Kubiak and Cortina 2003; Wilmsen-Thornhill and Thornhill 1991; Weinrath 2000; Yamawaki 2007).
- Secondary victimization by the system is a real risk (Amstadter et al. 2007; Campbell et al. 1999; Hagemann 1992; Norris et al. 1997).

- Interviewers need to be aware of problems associated with victim characteristics, such as intellectual disabilities (Cederborg and Lamb 2008) and other cognitive problems that might affect reporting.
- Dissociation during or immediately following the crime is a strong predictor of PTSD (Halligan et al. 2003; Ozer et al. 2003).
- Trauma memories are more disorganized than non-trauma memories (Halligan et al. 2003).
- Initial dissociation (shock) may be adaptive in some cases in that it may interfere with encoding into the long-term memory (Bromberg 2003).
- There may be a narrowing of attention (Holman and Silver 1998).
- There is a need for social support (emotional, informational, appraisal and instrumental).
- Gather information aimed at helping the victim make decisions.
- Gather information about resources and common reactions.
- Emotional reactions need to be experienced and processed (Green and Diaz 2008; Hill 2004).
- Assess the victim's coping strategies.
- Many victims of crimes do not report the crime to authorities (Boeckmann and Turpin-Petrosino 2002; Garnetts et al. 1990; Herek et al. 2002; Janoff 2005; Kaysen et al. 2005; Kuehnle and Sullivan 2003).
- Crisis-intervention models may be useful in helping the victim overcome the initial challenges of surviving a crime (Calhoun and Atkeson 1991; Miller 1998). However, recent research shows no effect on later development of PTSD (Marchand et al. 2006), and some argue that debriefing is ineffective and possibly harmful (Kamphuis and Emmelkamp 2005).

Transition/Protection

- Active treatment may be initiated (Casarez-Levison 1992).
- Natural and professional supports could be accessed (Casarez-Levison 1992; Combalbert and Vitry 2007; Miller 1998).
- Applying the Transtheoretical Model of Change may help identify what level of service is needed (Prochaska et al. 1992).
- Dissociation may indicate later difficulties (Ozer et al. 2003).
- Interpersonal friction soon after the crime may be predictive of later PTSD (Zoellner et al. 1999).

- PTSD may be predictive of later anger problems (Orth et al. 2008).
- People with pre-existing personality disorder diagnoses (borderline personality disorder) can still benefit from treatment (Clarke et al. 2008).
- There may be active blocking of memories (Nordanger 2007; Thompson 2000).
- Victims may avoid crime-related reminders, either through drugs or alcohol or through active avoidance (Everly et al. 2000; Hagemann 1992; Janoff 2005. Manktelow 2007; Mezy 1988; Nordanger 2007; Wolkenstein and Sterman 1998).
- There is some evidence that viewing media reports of the crime can have a negative affect on victims (Maercker and Mehr 2006).
- Victims may engage in safety-oriented behaviours (Hagemann 1992).
- Victims may focus on meaning-making (Gorman 2001; Layne et al. 2001; Nolen-Hoeksema and Davis 1999; Thompson 2000).
- Victims may use social comparison to understand their experience of victimization (Hagemann 1992; Greenberg and Ruback 1992; Thompson 2000).
- Victims may engage in self-comparison activities focused on pre- or post-victimization changes ("survivor") (McFarland and Alvaro 2000).
- Victims need to be informed that entering treatment may mean getting worse before getting better (Nishith et al. 2002).
- Treatments of PTSD including an exposure element seem to be effective (Bryant et al. 2003; Hembree and Foa 2003; Nishith et al. 2002).
- Self-efficacy may be important in treatment programs (Thompson et al. 2002);
- The treatment model can affect the program drop-out rate (McDonagh et al. 2005).
- Emotionally engaged clients recover faster (Gilboa-Schechtman and Foa 2001).
- Victims may avoid victim service providers (Boccellari et al. 2007).

- Being employed may increase risk of poor coping, possibly because of the addition of work-related stressors (Boccellari et al. 2007).
- Emotion-focused coping may decrease distress (Green and Diaz 2007 and 2008).

Reorganization/Resolution

- Recovery does not mean returning to a pre-victimized state (Hagemann 1992).
- The Transtheoretical Model of Change may be useful in maintaining new, healthier behaviours (Prochaska, DiClemente and Norcross 1992).
- Victims may focus on how surviving indicates strength (Hagemann 1992; Thompson 2000).
- Any remaining negative coping strategies need to be minimized (Dempsey 2002).
- Activism is a possible long-term outcome of victimization (Hagemann 1992).
- Victims may attribute physical problems to dealing with the negative effects of trauma (Manktelow 2007).

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Part Two: Specialty Chapters

9.0 Victims of Hate and Hate Crimes

Introduction

Helping victims of any crime can be a challenging, but rewarding activity. Although one is focused on the criminal event and helping the person make sense of this potentially traumatic experience, it is even more important to focus on the person. With victims of hate crimes, the personal/professional relationship can be even more delicate and important, as both of you face the impact of what has happened. This chapter focuses on the issues that workers need to think about when working with victims of hate and hate crime, raises important treatment issues, and gives workers some ideas about how to work with this group of victims and help them reconnect to their lives.

In the review of the research, hate crimes were explored as a whole and not broken down by specific types of victimization based on, for example, race, religion, or sexual identity. Although there are special issues and elements to each group, such as historical treatment in society, the goal of this chapter is to pull out issues that are likely important to working with any victim who feels that bias and prejudice are part of the reason they were victimized. Readers are strongly encouraged to look into research and issues specifically related to each client's needs. This chapter is a springboard to discuss the issues in general and give workers a framework to follow-up with their own learning.

Finally, a quick note on working with victims of hate crime, cultural issues and working with victims from these communities: Most victims of hate crimes are also members of groups that are not part of dominant culture. This is why the perpetrator targeted them. Prejudice and discrimination are issues that many people in these groups deal with on a daily basis. This daily reality will act as a lens that the hate crime victim uses to understand the criminal justice system, the police, and victim services workers and when asking for help. Workers can use this chapter to decide how they might best help the person cope with that victimization, as well as to understand the social reality the victim faces each day.

This chapter first focuses on the definition of hate crimes, to give workers an idea of the scope of what might happen to victims. The chapter then moves to general issues that workers need to understand when dealing with sensitive issues around culture, prejudice and society. The chapter continues with a focus on the psychological impact of being a hate crime victim, including suggestions on what workers might do. Finally, service-provider issues are reviewed and a resources section is provided for workers seeking additional information on this topic.

Definition of Hate Crime

For the purpose of this chapter, the following definition of "hate crime"[6] will be used:

> [A] criminal violation motivated by hate, based on race, national or ethnic origin, language, colour, religion, sex, age, mental or physical disability, sexual orientation or any other similar factor.
>
> Uniform Crime Reporting Survey 2.2 Definition[7]

Hate crime is addressed through sections 318 (advocating genocide) and 319 (public incitement of hatred) of the *Criminal Code* (R.S. 1985, c.C-46), as well as through the sentencing provisions of the *Criminal Code*, found in subsection 718.2 (a)(i). Those sentencing provisions provide that courts should consider "evidence that the offence was motivated by bias, prejudice or hate based on race, national or ethnic origin, language, colour, religion, sex, age, mental or physical disability, sexual orientation, or any other similar factor" as an aggravating factor when determining the sentence to be imposed. Further, there is a specific provision found in subsection 430 (4.1) with respect to mischief against property used for religious worship.

As a clinician, however, my approach does not come from a legal or policy position; it comes from the victim's definition of the crime. If the victim believes hate, bias or prejudice was part of the reason for being victimized, then I would work with him or her, using many of the principles and issues raised in this chapter, even if I did not agree with

6 The terms "hate-motivated crime" and "bias-motivated crime" are also used in the literature.

7 In Canada, official crime statistics, also known as police-reported crime data, have been systematically collected since 1962 through the UCR Survey. Updates to the survey (now version 2.2) reflect changes in the *Criminal Code*. All police services participate in the survey by submitting data to the Canadian Centre for Justice Statistics (CCJS), which is part of Statistics Canada, according to a nationally approved set of common crime categories and definitions.

that assessment. Victims of all crime need empathy and understanding, and allowing them to explore their experience of the crime will help them better understand what has happened (Teyber 2006).

Part of developing this understanding involves looking at the range of criminal behaviour that might be seen as a hate crime. Boeckmann and Turpin-Petrosino (2002) point out that hate crimes can range from almost meaningless juvenile delinquency (such as causing damage to a synagogue during a night of general vandalism) to a more organized political statement (such as the burning of a synagogue by an organized hate group). Much of the research and writing in the area discuss intimidation, harassment, vandalism (homes/business), vandalism of religious property, personal assaults (physical and sexual) and homicide (Barnes and Ephross 1994; Cheng 2004; Garnetts et al. 1990; Jacobs and Potter 1998; McPhail 2002). Although most research is on hate crime within communities, the Internet has been identified by several authors as a new medium through which hate groups and individuals can promote their views (Adams and Roscigno 2005; Boeckmann and Turpin-Petrosino 2002; Glaser et al. 2002; Mock 2000). *The Canadian Human Rights Act*, in subsection 13(1), prohibits hate messages; it was amended in 2002[8] to make clear that hate messages include Internet messages (see Mock (2000) for a discussion on free speech versus hate speech). Workers are reminded that all hate crimes involve illegal behaviour. In the case of hate crimes, however, the perpetrator's motivation involves bias and prejudice against the victim or the group.[9]

Another element of hate crimes is that they send a message to the greater community. Although the specific crime may target an individual, the perpetrator's goal is to spread fear into the victim's community (Blee 2007; Dauvergne et al. 2008; Mock 1995, 2002; Petersilia 2001). A central element of understanding hate crimes is what Berk, Boyd and Hamner (1992) refer to as the "but for" characteristic of hate crimes: "But for" the biased view of the perpetrator, the crime would not have occurred. The focus is on harming the person because of his or her group membership, not individual characteristics (Blake 2001). The victim is targeted to bring about harm to the group represented, not the individual. This interchangeability of a victim as a representative of the larger group is another marker of a hate crime (Jacobs and Potter 1998; McDevitt et al. 2001).

8 2001, c. 41, s. 88.

9 Those interested in a more in-depth discussion of the issues related to hate crimes should read the final report of the Hate Crimes Community Working Group (2006), entitled *Addressing Hate Crimes in Ontario*. This report goes into much greater detail on history, definitions, legislation, advocacy, etc.

Although strangers committed 77% of violent hate crimes reported to police in Canada (Dauvergne et al. 2008), sometimes the crime can have a personal element. There is research that suggests that many victims who report hate crimes do know the perpetrators, even if only casually (Mason 2005). For example, the victim may be a known lesbian in the community who is being harassed by a neighbour. In fact, research specifically on lesbian victims shows that they are more likely to be targeted by family, friends and acquaintances than strangers (Stermac and Sheridan 1993). Thus, workers should be mindful when gathering information and not assume that the hate crime was a "stranger" crime.

Common Issues

Culture

Culture refers to a set of shared meanings that form a structure for social relationships (Truscott and Crook 2004). Each of the communities targeted in hate crimes (race, national or ethnic origin, language, colour, religion, sex, age, mental or physical disability, sexual orientation, or any other similar factor) can be seen from a cultural perspective as being different from the dominant culture or as having different norms. Workers, however, must not make the same mistake as the hate crime perpetrators: each victim is an individual and cannot simply be seen as a member of the group. Workers need to be aware of community norms, but must also keep in mind that this person has a unique perspective that must be the focus (Truscott and Crook 2004).

For the purposes of this chapter, we will be taking a broad definition of culture that includes many elements of identity. When references are made to the dominant culture or the dominant group, these terms represent those in the general culture. This would be roughly defined in Canada as the white (Northern European), middle-class, heterosexual and able-bodied group. However, it is important to note that the values and specific make-up of a dominant culture will vary in different parts of the country. Readers are reminded that dominance does not refer to the most numerous, but to those who have more power (social/economic/political) and define what is "normal."

Prejudice in society

All crimes occur within a social context. There are social, economic, family and personal pressures on both the victim and the perpetrator of crime. However, many argue that hate crimes also need to be understood within the context of living in a prejudicial society (Garnetts et al. 1990; Herek et al. 1997; Perry 2002; Willis 2004). That is, within our society there are people and behaviours that are seen as acceptable and "normal" and those that are seen as "different." Often those seen as different can be the target of prejudice and, potentially, hate-motivated crimes. Reviewing the list of those who are the victims of hate crimes, workers will notice that all of them are typically people who are seen as outside or on the fringe of society (Kaysen et al. 2005). Beyond the context of crime, workers need to realize that this in-group/out-group dynamic may cause a great deal of distress to the victim and his or her family (Ardley 2005; Bryant-Davis and Ocampo 2005; Dunbar 2001; Glaser et al. 2002; Mock 1995). Coping with prejudice may be part of her everyday experience, and this will likely become part of any work with the victim (Teyber 2006).

This chapter will not be discussing perpetrator motivations in detail; however, it is appropriate to draw attention to prejudice in this section. In discussing racism, the British Columbia Human Rights Coalition (2003) defined prejudice as "beliefs or attitudes about an individual or group based on negative or positive stereotyping". The Coalition points out that we learn stereotypes in our family and communities and, as we come to believe stereotypes, bias is created that can affect behaviour. When we act on these biases it becomes discrimination, and when combined with a criminal act, it becomes a hate crime (British Columbia Human Rights Coalition 2003). As a reflection of prejudice in society, often the perpetrators view their own actions as just and correct (McDevitt et al. 2002). Thus, it may be seen as acceptable to intimidate or harass visible minorities in the workplace or at school or to go to known gay areas and yell at people on the street. This bias can be viewed in the context of coming from a society that supports prejudice. For instance, in looking at hate crimes after 9/11, Gerstenfeld (2002) noted that some perpetrators viewed their criminal actions as positive, righteous and patriotic. This is obviously a reflection not only of their personal views, but of views among their communities, families and friends (Gerstenfeld 2002; Staub 1996).

Reporting the crime

Much has been written about how many victims of hate crimes do not report the crime to authorities (Boeckmann and Turpin-Petrosino 2002; Garnetts et al. 1990; Herek et al. 1999; Herek et al. 2002; Janoff 2005; Kaysen et al. 2005; Kuehnle and Sullivan 2003; Wolff and Cokely 2007). Recent reports from Statistics Canada indicate that 60% of hate crimes are not reported to police (Dauvergne et al. 2008). Several researchers have noted that victims may be reluctant to report hate crimes because of fear of secondary victimization and/or fear of the reaction of the police or other responders (Herek et al. 2002; Peel 1999; Wolff and Cokely 2007). Even members of the public might blame the victim for "bringing the crime upon himself" (Herek et al. 1999; Lieberman et al. 2001; Wolff and Cokely 2007). This relates directly to the issues raised in looking at our society as being prejudiced.

These researchers have also identified several other reasons people gave for not reporting hate crimes (Herek et al. 2002; Peel 1999):

- The crime was not important or it was unlikely police would catch the perpetrators.
- The person saw it as a personal matter. This might include harassment from family, co-workers, classmates, etc.
- The person felt to blame or was embarrassed about being victimized.
- The person did not believe it was a crime.
- The person fixed, or tried to fix, the problem and did not think they needed to contact the police.

The victim's previous experiences can also affect whether he or she will report the crime. Stermac and Sheridan (1993) point out that victims who belong to more than one minority group are at higher risk of being a victim of hate crime and are at increased risk of facing discrimination in society. This feeling of not being accepted because of multiple labels may also decrease the chances she will report the crime (Dunbar 2006). Thus, an Aboriginal lesbian might be less likely to report a hate crime than a white lesbian. Dunbar (2006) also indicates that for victims of gay bashing, the more violent the attack the less likely it is to be reported. Workers may need to help victims look at the cost and benefits of reporting the crime to authorities (Garnetts et al. 1990).

Given the above, some researchers have looked at those who did report hate crimes. McDevitt et al. (2001) noted that hate crime victims were more likely to talk to other people before reporting the crime. This may relate to all crime victims' need to decide whether what happened was a crime or to seek other types of support. Peel (1999) indicated that those who report hate crimes are more likely to view the police as effective and to report that they did not want the perpetrator to "win." However, those who reported also felt more fear about reporting the crime (Peel 1999).

Waves of victims

Although the criminal act harms the primary victim, there are also many secondary victims (Ardley 2005; Blee 2007; Jacobs and Potter 1998; McDonald and Hogue 2006). Iganski (2001) described "waves of harm" which move out from the initial victim to the initial victim's group/neighbourhood, initial victim's group beyond the neighbourhood, other targeted communities, social norms and values. Hate crimes send a clear message to the initial victim's community that they are not welcomed or accepted in society (Jacobs and Potter 1998) regardless of whether they live in the immediate area (Blee 2005). For example, if a synagogue in Montreal is vandalized, this can affect the feelings of safety and security of a Jewish person in Vancouver. One might observe increased feelings of fear, lack of safety and vulnerability in all members of the targeted community (Boeckmann and Turpin-Petrosino 2002; Jacobs and Potter 1998; Herek et al. 2002; Jenness and Broad 1997; Mock 1995 and 2002). This can result in even greater feelings of being marginalized.

Psychological Impact

Many writers in the field agree that hate crimes have an impact on the victim above and beyond that of the criminal act in itself (Ardley 2005; Boeckmann and Turpin-Petrosino 2002; Iganski 2001). Although many of the reactions listed in this section might be common to any crime victim, researchers have identified these as being particularly important for victims of hate crime. Indeed, they may simply be a reasonable reaction to the extraordinary stress of being targeted by the perpetrator and harmed because of characteristics beyond the victim's control (Bryant-Davis and Ocampo 2005; Craig-Henderson and Sloan 2003).

Research specifically on victims of hate crimes indicates that, like other victims, they often:

- feel less secure (Boeckmann and Turpin-Petrosino 2002; Garnetts et al. 1990; Janoff 2005; Staub 1996);
- see the world as less orderly and meaningful (Garnetts et al. 1990);
- have lower self-worth (Dunbar 2006; Garnetts et al. 1990; Mock 1995; Janoff 2005);
- feel less effective (Staub 1996);
- have problems in personal relationships (Janoff 2005; Staub 1996);
- feel guilty and blame themselves (Dunbar 2006; Wertheimer 1990);
- question their ability to protect themselves (Staub 1996);
- feel they cannot meet goals in life (Staub 1996);
- have anger at the larger community or sub community (Herek et al. 1997; Janoff 2005; Staub 1996);
- have depression (Herek et al. 1997; Janoff 2005);
- have anxiety or post-traumatic stress (Garnetts et al. 1990; Herek et al. 1997; Janoff 2005);
- experience headaches, nightmares, crying, agitation, restlessness, weight loss (Garnetts et al. 1990; Janoff 2005); and
- have increased use of drugs and alcohol (Janoff 2005).

Differences from other victims

There are some differences between hate crime victims and victims of non-hate crimes. The following results are from research that directly compared victims of hate crime to similar (i.e., same community) victims of non-hate crimes to note differences in reaction. In most cases, the response is similar to what is seen in any victim of crime (see Table 1 in Part One), but there is greater negative impact on those who have experienced hate crime.

In comparison to other victims, hate-crime victims are more likely to:

- suffer brutal attacks (Janoff 2005; Willis 2004) – and are almost three times more likely to experience severe injury (Messner et al. 2004);
- report more distress (Dauvergne et al. 2008; Herek et al. 1997; Herek, Gillis and Cogan 1999; McDevitt et al. 2001; Mjoseth 1998);

- report higher levels of fear (Craig-Henderson and Sloan 2003; Dauvergne et al. 2008; Herek et al. 2002; McDevitt et al. 2001);
- report higher levels of depression, anxiety, anger and PTSD symptoms (Herek et al. 1997; McDevitt et al. 2001) – though other researchers have found no differences between the two groups with respect to depression (Rose and Mechanic 2002);
- see others as dangerous (Herek et al. 1997; Herek et al. 1999);
- see the world as unsafe (Dauvergne et al. 2008; Herek et al. 1999; McDevitt et al. 2001);
- rate their risk of future victimization as higher than it had been (Herek et al. 1997);
- show a relatively low sense of personal mastery (Herek et al. 1999);
- see personal setbacks as related to prejudice (Herek et al. 1999);
- report finding it "very difficult" to overcome the incident (McDevitt et al. 2001);
- report the incident as having had a big impact on their lives (Craig-Henderson and Sloan 2003; Dauvergne et al. 2008);
- report having more intrusive thoughts of the incident and feeling like they do not want to live any longer (McDevitt et al. 2001);
- lose their jobs (McDevitt et al. 2001); and
- report significant health problems (McDevitt et al. 2001).

Workers will want to pay close attention to these and other issues that they are used to seeing in other crime victims. One possible explanation for the more extreme reaction in hate crime victims is that the perpetrators have chosen their victims based upon characteristics that the victims cannot easily change (Blake 2001; Craig-Henderson and Sloan 2003; McDevitt et al. 2001), which makes it more difficult for them to rebuild belief in a safe world. Furthermore, after the hate crime, the victim is still likely to encounter other bias and prejudice that will re-emphasize that some in the dominant society do not accept them (Ardley 2005; Garnetts et al. 1990; Herek et al. 1997; Willis 2004).

Identity issues

Workers will note that many clients who are victims of hate crimes will have issues involving how they see themselves, others and their relationships. Identity includes feelings of belonging to the group; group-specific behaviors and practices; and exploration of and commitment to the group (Dubow et al. 2000). Several authors indicate that those

victims who identify and define themselves with their community can be at greater risk for developing symptoms after being a victim of a hate crime (Dubow et al. 2000; Janoff 2005) or any prejudicial acts (Moradi and Risco 2006). This may be because the victim has experienced an attack on himself and because of how he sees himself (Blake 2001; Kaysen, Lostutter and Goines 2005; Staub 1996). Others point out, however, that those who do not have strong bonds to the identity characteristics targeted in the crime may be more likely to blame themselves, feel worthless and not report the crime (Boeckmann and Liew 2002). Workers need to assess how important group identity issues are to the victim. By knowing whether or not a victim highly identifies with his group, workers might better predict the types of problems the victim might face and be able to refer him to supports accordingly.

On the other hand, researchers also note that those who have a strong community identity can also look to teachings and people from their group for ways to cope (Adams et al. 2006; Dubow et. al 2000; Mock 1995). They are also more likely to have a social support within the community which will help them make sense of what has happened (Blee 2005; Janoff 2005; Miville et al. 2005). Furthermore, they may be more likely to report the crime, seek help and strengthen their identity with their community (Boeckmann and Liew 2002). Research on diverse ethnic and cultural groups indicates that many people use group status and identity as a way of understanding themselves and their world (Alvarez et al. 2006; Chen et al. 2006; Miville et al. 2005; Wester et al. 2006). This understanding can have a major impact on how the person makes meaning about their victimization. Workers should encourage those victims who have a strong sense of group identity to access supports within their community, as well as other supports. This will also help them make meaning that fits both their relationship to their particular group and the dominant society (Craig-Henderson and Sloan 2003; Dunbar 2001).

The main goal in working with any crime victim is helping him move on from the crisis of the criminal victimization and rebuild his life. If needed, this process includes helping gain new understanding about how he now fits into his specific group as well as to the dominant culture (Dunbar 2001). With multi-racial victims or victims from different identity groups (e.g. black Catholic and gay), healing may also include helping access strengths and identity from several different communities (Miville et al. 2005). Rosenwasser (2000) describes a

group process called cooperative inquiry wherein people work together to develop their identity in the face of challenges. The process includes elements that help members build a healthy identity with respect to their group and society in general. It appears this acceptance of one's own community identity and setting boundaries around dealing with the dominant culture helps people move forward in a healthy manner.

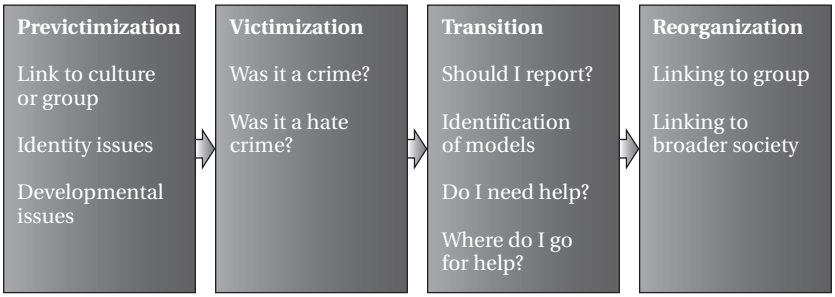
Although this chapter has not generally focused on one group, there is an issue specific to gay, bisexual and lesbian clients that is worthy of note. Several researchers have noted that these clients may react to being attacked by questioning their decision to be "out" (Cheng 2004; Garnetts et al. 1990; Janoff 2005; Stermac and Sheridan 1993). Thus, workers may find that victims want to hide their sexuality again and may confront issues that they faced when they came out (Janoff 2005). Several other authors discuss internalized homophobia, wherein the person adopts the negative view of the greater society on homosexuality (Kaysen et al. 2005). Although this is a specific issue raised around sexual identity, it is easy to see that any hate crime victim might have a similar response of trying to minimize any differences in order to fit into the dominant culture.

Issues involving support networks

As noted above, there are waves of victims, and hate crimes affect all community members. We need to work with the victims to help identify key people in their support networks who can help them make meaning of the crime. This is especially true if you are not from the same group as the victim. Further, workers may also need to work with those in the support network who may need to come to terms with their reactions to hate crime, possibly dealing with their own victimization history and reactions (Garnetts et al. 1990). In essence, the victim must strike a balance that allows him or her to access support but not overwhelm the network. Survivor guilt often occurs in the victim's support network or in others from the same group (Bryant-Davis and Ocampo 2005). Blee (2007) points out that there can be very different reactions within members of the same group, even in defining the crime as a hate crime. This may mean the victim may encounter disbelief, disagreement or non-support within family or a specific community. Thus, workers need to educate victims about possible reactions of their network, help them understand those reactions, and help victims succeed in reconnecting to their networks.

Treatment Issues

Figure H1: The process of victimization and recovery (Casarez-Levison 1992) applied to hate crimes



A major goal of treatment is to help victims make sense of the crime and start the healing process (Cheng 2004; Craig-Henderson and Sloan 2003). Figure H1 adapts Casarez-Levison's (1992) model to incorporate the information reviewed in earlier sections to highlight some of the issues workers need to be aware of in helping hate crime victims. There are many matters that are important to all victims of crime, such as history of previous victimization, history of trauma, mental health issues, normal coping mechanisms, healthy behaviours, current victimization issues, access to support networks, and so forth. Dunbar (2001) offers an excellent discussion of the key issues to cover when working with victims of hate and hate crime. The following issues may arise when working with victims from marginalized identity groups or victims of hate crimes.

Questions/Issues to Raise

1) Assess whether the person has a strong bond to the identity targeted by the crime (Dunbar 2001). As noted above, this connection can offer resiliency (Adams, et al. 2006; Dubow et. al 2000; Mock 1995) but it can potentially result in more challenges (Blake 2001; Dubow et al. 2000; Janoff 2005; Kaysen et al. 2005; Moradi and Risco 2006; Staub 1996). It is important that you not try to impose your personal view of what they should do. Allow your clients to lead you in how much, or how little, they want to use group identiy to shape their personal identity.
2) Workers may need to address directly their ability to work with the victim (Dunbar 2001; Teyber 2006). The person has been through a difficult situation and will need to feel comfortable with you and believe that you are not only skilled in your work but also knowledgeable about his issues and those of his or her

community. Workers may want to connect with key people in the community to help educate themselves on important issues to the group. Workers might also seek consultation from others more familiar with the issues, transfer the victim to those workers, or discuss their concerns with their supervisors.

3) Watch for, and highlight, any displays of resilience or strength. This is especially true of resilience around the strengths of identity group (Adams, et al. 2006; Dubow et. al 2000; Dunbar 2001; Mock 1995). This helps victims see how they are part of a meaningful network, helps them access appropriate models of how to deal with the distress, and helps them focus on change and adapting to relating to problems with the dominant group. This must be balanced with developing understanding of the dominant group to ensure that victims do not succumb to anger at society at large (Dunbar 2001; Janoff 2005).
4) Get a history of his or her experiences in dealing with the more dominant culture (Boeckmann and Liew 2002; Dunbar 2001). Was this the first experience with prejudice? Were there positive experiences as well? This history also allows workers to explore what the victim's relationships have been with the dominant culture or with the group the worker represents. In fact, workers may find that victims of hate crimes will be even more curious about the worker's identity and beliefs around these issues (Dunbar 2001; Teyber 2006). Workers are encouraged to talk to colleagues and supervisors about their comfort level and boundaries to ensure they are able to answer such questions in a way that is both helpful and respectful.

Continuum of Services

As noted above, hate crimes affect all of society and the impact goes far beyond the direct victim (Barnes and Ephross 1994; Iganski 2001 McDevitt, et al. 2001). Thus, services need to include normal crisis intervention, short-term, long-term, group and individual support (Dunbar 2001; Wertheimer 1990), and go beyond to community interventions and education. Workers might want to look for public education information, anti-violence campaigns and training on dealing with prejudice and violence (Jenness and Broad 1997; Lieberman et al. 2001; Mock 1995; Mock 2002; Rabrenovic 2007). Advocacy can also be an important role in addressing the needs of all victims of hate crimes (B. C. Human Rights Coalition 2003; Blee 2005; McMahon, West, Lewis, Armstrong and Conway 2004). In essence, workers can help the direct victim but also support efforts to reduce the trauma in the overall community (Espiritu 2004).

Although the focus of this chapter is on working with individual crime victims, many have argued that since the main target of hate crimes is the community targeted (e.g. Jewish, gay, francophone), interventions also need to target the community (Blee 2005; Espiritu 2004; Rabrenovic 2007). Mock (1995; 2002) indicates that in Canada there have been various community-level interventions. These might include promoting changes to laws, educating the public, encouraging community development, running proactive campaigns to counter hate groups, and so forth (B. C. Human Rights Coalition 2003; Mock 2002; McDonald and Hogue 2006; Rabrenovic 2007). The key to these community education interventions is to train all community members in less prejudicial beliefs in hopes of affecting their behaviour (Gerstenfeld 2002; Mock 1995). Workers interested in community-based efforts might want to review the Web sites in the "Web-based Resources" section later in this chapter.

Provider Issues

Workers are encouraged to follow the self-care strategies outlined in chapter one of the original manual. Two related issues that might be important to think about when working with victims of hate crimes are personal bias; and openness and acceptance.

Personal bias

We must be very clear and frank regarding our personal biases about the victim's community and cultural values (Dunbar 2001). This is central to building trust in the working relationship (Teyber 2006). Workers may want to seek consultation over any biases, no matter how minor (Cheng 2004). Further, workers need to be cautious that in trying to be fair that they do not treat all clients the same. So-called "culture blindness," not seeing the world as the client sees it, and trying to treat everyone the same can cause workers to be insensitive to the specific issues of the victim's community (Truscott and Crook 2004). A worker's approach should fit the experiences and strengths of each client. Part of dealing with personal bias is also facing areas of subtle bias. We need to watch for using global characteristics as a way to describe the victim – for example, referring to "the Pakistani victim," which would indicate that race is that person's most distinctive characteristic (Perry 2002; Stermac and Sheridan 1993). Finally, in understanding personal biases, it can be important to acknowledge that we all live in a biased society that influences our perceptions and meaning-making (Cheng 2004).

Openness and acceptance

In working with victims of hate and hate crimes, workers need to assess their comfort with the victim and his community. Dunbar (2001) points out that you should assess your own skills and knowledge in working with a member of the group in question. Are there differences between your worldview and that of your client? How might these differences affect your work? Are there other issues that might interfere with your work together? Teyber (2006) points out that with all clients one should provide a safe, open and accepting environment. However, he also notes that many of those from groups with less power (minority, sexual identity, religion, etc.) will often not expect to be heard or understood because of their experiences of prejudice in the broader culture. Workers need to be aware of this challenge in building trust and a good working relationship.

We need to provide an environment of non-judgmental support (Craig-Henderson and Sloan 2003) while also attending to professional boundaries and the victim's comfort around talking about difficult issues (Wertheimer 1990). Thus, workers need to be aware that many victims of hate crimes will be watchful of any potential bias on the part of those helping them. We can often show subtle bias in seemingly innocent ways that may cause problems in the support relationship (Truscott and Crook 2004). For example, office decorations, reading material and personal items may be welcoming to some but distancing to others. Although this is not to advocate creating a sterile support environment, it is helpful to be aware of the messages we send victims when they come seeking help.

Web-based resources

There is much on the Internet that you can access to learn more about working with victims of hate crimes, those who are coping with prejudice or even simply to understand different groups within our society. Using any search engine will take you to useful resources. The following sites are mentioned as means of quickly getting useful information. You are encouraged to do your own search, focusing on issues specific to your client.

The Anti-Defamation League is an organization whose goal is to stop anti-Semitism and other forms of social injustice and discrimination. http://www.adl.org/default.htm

B'nai Brith Canada describes itself as "the independent voice of the Jewish community, representing its interests nationwide to government, NGO's and the wider Canadian public."
http://www.bnaibrith.ca/

The Canadian Human Rights Commission investigates and addresses complaints of discrimination in employment. The Commission also develops information and conducts discrimination-prevention programs.
www.chrc-ccdp.ca

Canadian Race Relations Foundation is a Crown corporation that has a mandate to fight against racism in Canada.
www.crr.ca

Canadian Jewish Congress is a Jewish organization focused on fighting anti-Semitism.
http://www.cjc.ca

Council of Agencies Serving South Asians is a coalition of agencies, groups, and individuals that provide services to the South Asian Community.
http://www.cassa.on.ca

Cross Point Anti-Racism is an international organization that fights racism.
www.magenta.nl/crosspoint

GayCanada.com is an online gay, lesbian, bisexual, transgender people's virtual community that includes links to resources subdivided by province.
http://www.gaycanada.com/

PFLAG Canada provides support, education and resources on issues of sexual orientation and gender identity for gay, lesbian, bisexual and transgendered persons, their families and friends. You may be able to find a local chapter through an Internet search.
www.pflagcanada.ca/

Religious Tolerance.org is a multi-faith group focused on religious and social tolerance.
http://www.religioustolerance.org

Safe Canada contains hate crimes links and may be a good place to start an Internet search on hate crimes.
http://www.safecanada.ca/link_e.asp?category=2&topic=23

The Basics

- A hate crime is "a criminal violation motivated by hate, based on race, national or ethnic origin, language, colour, religion, sex, age, mental or physical disability, sexual orientation or any other similar factor" (Uniform Crime Reporting Survey 2.2 Definition).
- Workers helping victims should focus on how the victim defines the crime, not just on legal definitions.
- Hate crimes create "waves of victims," harming the victim, his or her family, identity group and society at large.
- Workers should be aware of the importance of how the victim views his or her community and personal and cultural identity, and how they have faced and coped with prejudice in society.
- It would be helpful if workers could assess what supports the victim has in the community and whether he or she has good coping models.
- Many victims of hate crimes do not report the crime to authorities. Workers may face this reluctance to report in working with hate crime victims.
- Victims of hate crimes often:
    - feel less secure (Boeckmann and Turpin-Petrosino 2002; Garnetts et al. 1990; Janoff 2005; Staub 1996);
    - see the world as less orderly and meaningful (Garnetts et al. 1990);
    - have lower self-worth (Dunbar 2006; Garnetts et al. 1990; Mock 1995; Janoff 2005);
    - feel less effective (Staub 1996);
    - have problems in personal relationships (Janoff 2005; Staub 1996);
    - feel guilty and blame themselves (Dunbar 2006; Wertheimer 1990);
    - question their ability to protect themselves (Staub 1996);
    - feel they cannot meet goals in life (Staub 1996);

- have anger at the dominant community (Herek et al. 1997; Janoff 2005; Staub 1996);
- have depression (Herek et al. 1997; Janoff 2005);
- have anxiety or post-traumatic stress (Garnetts et al. 1990; Herek et al. 1997; Janoff 2005);
- experience headaches, nightmares, crying, agitation, restlessness, weight loss (Garnetts et al. 1990; Janoff 2005); and
- make increased use of drugs and alcohol (Janoff 2005).

- In comparison to non-hate crime victims, hate crime victims are more likely to:
  - suffer more brutal attacks (Janoff 2005; Willis 2004), and are almost three times more likely to experience severe injury (Messner et al. 2004);
  - report more distress (Herek et al. 1997; Herek et al. 1999; McDevitt et al. 2001; Mjoseth 1998);
  - report higher levels of fear (Craig-Henderson and Sloan 2003; Herek et al. 2002; McDevitt et al. 2001);
  - report higher levels of depression, anxiety, anger and PTSD symptoms (Herek et al. 1997; McDevitt et al. 2001). However, other researchers found that there were no differences between the two groups with respect to depression (Rose and Mechanic 2002);
  - see others as dangerous (Herek et al. 1997; Herek et al. 1999);
  - see the world as unsafe (Herek et al. 1999; McDevitt et al. 2001);
  - rate their risk of future victimization as higher (Herek et al. 1997);
  - show a relatively low sense of personal mastery (Herek et al. 1999);
  - see personal setbacks as related to prejudice (Herek et al. 1999);
  - report overcoming the incident as “very difficult” (McDevitt et al. 2001);
  - report the incident as having a big impact on their lives (Craig-Henderson and Sloan 2003);
  - report more intrusive thoughts of the incident and feeling like they do not want to live any longer (McDevitt et al. 2001);
  - report having lost a job (McDevitt et al. 2001);
  - report significant health problems (McDevitt et al. 2001).

Workers should examine their personal biases and boundaries in working with hate crime victims. Are they able to provide an open environment to help the victim move forward?

Workers are encouraged to use the Internet to find resources specific to their client's identity group and issues.

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10.0 Victims of Terrorism

Introduction

The focus of this chapter is on the person who comes to your office who has been harmed by terrorism. As we discuss the impact of terrorism, we will first define terrorism, focusing on the effects the terrorist wants to create. In that definition, the distinction will be made between single-incident terrorist attacks and ongoing terrorist activity.

We will then discuss the levels of victimization: from primary victimization to secondary victimization and the effects on those in society. The chapter will conclude with a review of the emotional and psychological effects of being a terrorist victim and important clinical issues. Finally, specific service-provider issues will be briefly noted, including a section on Web-based resources.

Terrorism defined

Although terrorists and other criminals may use the same violent means to reach their goals, terrorism can be distinguished by the following:

1. use of force or violence;
2. by individuals or groups;
3. directed toward innocent civilians;
4. intended to influence or force changes in political or social decisions and policies;
5. by instilling fear and terror.
   (Marsella and Moghaddam 2004: 23).[10]

Thus, terrorists engage in violent criminal behaviour to meet political ends by putting pressure on decision makers and society (Ganor 2004). By focusing on political leaders and general community members, terrorists spread fear throughout society to increase attention to their political cause (Danieli, Brom and Sills 2004).

The unpredictable nature of the violence is the core part of psychological warfare the terrorist uses to harm the community (Chemtob 2005; Ganor 2004). The role of media is important to the terrorist because it helps to spread fear and meet political goals; this is also a particular challenge to those recovering from trauma (Adessky and Freedman 2005; Pfefferbaum et al. 2004; Substance Abuse and

10 The Canadian *Anti-terrorism Act* can be found on the Department of Justice Canada Web site at: http://laws.justice.gc.ca/en/search.

Mental Health Services Administration (SAMSA) 2004; Weimann 2004). The challenge for people in the community is not only that they may react to the initial incident, but also that repeated reminders of the attack on news programs might deepen any trauma. In essence, the repeated media coverage of the terrorist attack helps to keep the attack and the terrorists' political goals on the front burner.

Some researchers highlight the division of sub-state terrorism (non-government affiliated) and state-sponsored terrorism (supported by governments) (Marsella and Moghaddam 2004). It should be noted that state-sponsored terrorism adds the difficulty for victims of not having government support for prevention and treatment. In these cases, the government itself plans, finances or provides support to terrorist activities, typically against a subgroup in the country (Danieli et al. 2004). Workers delivering services to victims of state-sponsored terrorism may find even greater issues of mistrust in the helping relationship, especially trust in authority or government figures. For example, victims may feel that they might not get help and may not trust how information may be used and so refuse to contact the police.

Similar to other crimes, terrorism strikes at the heart of viewing the world as a safe and predictable place (Davidowitz-Farkas and Hutchison-Hall 2005)[11]. Part of the community's way of coping with terrorism is to accept it as the "new normal." Danieli et al. (2004) point out that since 9/11, North Americans have developed new rules of how to act and relate to other people and the government. In other words, all of us have had our view of a safe world affected.

Ongoing terrorism or war can have a slightly different impact on the community. People are reminded frequently of the unsafe world; attacks become a reality of everyday life. These victims will often use many of the coping strategies discussed in earlier chapters such as distancing, denial or just acceptance of the reality of unpredictable attacks (Campbell et al. 2004; Wessely 2005). Researchers note that the ongoing threat of terrorism increases suspicion, distrust, and hopelessness in the general community, and breaks down social connections (Chemtob 2005: Engdahl 2004; Khaled 2004; Somasundaram 2004).

11 It is worth noting that natural disasters also challenge people's views of the world as a safe place; however, the fact that other people commit terrorist attacks makes them more similar to other violent crimes. The types of supports needed will be more similar to those needed by victims of other violent crimes.

Looking at this more positively, some believe that such ongoing threats may also bring about positive personal and social change, so-called "post-traumatic growth" (Engdahl 2004; Fredrickson et al. 2003). Fredrickson et al. (2003) noted that positive emotions such as gratitude, interest or love helped people cope after the 9/11 attack and avoid depression. Many writers point out that professionals, paraprofessionals and the public at large can work together to build community strength (Berger 2005; Durodié and Wessely 2002; Heldring and Kudler 2005; Sederer et al. 2005; Sofka 2004; Somasundaram 2004).

Special Issues

Victim Continuum

Terrorists have little concern for the individual victim, focusing instead on society. Since an attack can affect a wide range of people, we need to look at a continuum of victimization – i.e. we need to understand victims of terrorism not just as one big group, but as a range of people defined by their exposure to the attack. Figure T1 contains a breakdown of the victim continuum; each level of victimization (direct, secondary, community) may have its own particular issues (Jordan 2002; Levanon et al. 2005; SAMHSA 2004). Workers should be aware of this continuum to get a greater understanding not only of the victim sitting in the office, but also of the people in her life. Workers should note that this continuum is based upon the victim's proximity to the location of the terrorist attack, not on the levels of potential trauma. Although one might guess that those closest to the attack will be more traumatized, this may not be the case. Personal history, previous trauma history, coping skills, and many other factors may affect how a person responds to an attack (Nader and Danieli 2004; Thielman 2004). However, there is research that indicates that direct victims of terrorism are more likely to report problems associated with PTSD, depression and anxiety (Gabriel et al. 2007; Whalley and Brewin 2007). Obviously, workers need to assess each victim's level of trauma and need on a case-by-case basis.

Figure T1: The Continuum of Victims

Direct or Primary Victims	Those victims that are in the immediate area of the terrorist attack. This group can be divided into those who were physically injured, tortured or killed and those who witnessed the attack or were threatened (near misses) but not physically harmed. There seems to be agreement in the research literature that the level of psychological trauma is directly linked to the amount of direct harm (Ahern, Galea, Resnick, and Vlahov 2004; Baca, Baca-García, Pérez-Rodríguez and Cabanas 2004; Jordan 2002). Thus, it is most likely that it will be these direct victims who show up in your office.
Direct Professional/ Volunteer Victims	People who are at the scene of the terrorist attack as part of their job or as volunteers. This includes police, fire fighters, emergency services workers, aid workers and other first responders who have much to do in their respective roles (Brom 2005). Reporters from the media are also included in this group. Many of these people may have some form of organizational training and support to deal with difficult experiences or trauma, but may still need support and further assistance from Victim Services.
Indirect or Secondary Victims	This group includes the direct victims family members, friends, co-workers, etc. All those people who are related to the victim in any way can be affected by the attack, the harm to their loved one and coping with changes in themselves and their loved ones. These are the "natural supports" of the victim (if the victim is still living). These people may need support in understanding their own reactions and emotions or may need support in coping with the direct victim. Workers need to get direction from the client to decide what will be most helpful. You may find it helpful to review Table 4 in this manual and think about what type of support your client might need.
Community or Tertiary Victims	Those people in the community who are affected by the attack. This may include people who have their daily routine affected, have work/school access problems, etc. This also includes those people who have been affected by images and reports on television. In a sense, the media creates other witnesses to the event, and these images can be very disturbing to some. Workers will need to gather a complete history to ensure they do not miss key issues (previous trauma, mental health issues, stressors, etc.) that might affect the reaction to the terrorist attack.
Re-victimized Victims	Those people who have been victims of previous terrorist attacks, but are now re-traumatized by a new attack or report of a thwarted attack. In other words, these victims may be deeply affected by television coverage of a current attack or a documentary of a previous attack (Ahern et al. 2004; Kinzie 2004). Furthermore, reminders of the original attack might cause any victim of crime to have difficulties coping. Workers need to help all victims learn to manage these potentially re-traumatizing experiences.

Trauma

The trauma commonly seen in victims of terrorism is much the same as the trauma associated with being a victim of any crime. Table 1 in the *Common Reactions to Crime* section of the main manual covers the issues that you will want to watch for in victims of terrorism. However, more needs to be mentioned on special issues with these victims including: acute stress and post-traumatic stress disorder, grief and complicated grief and survivor guilt. Workers are reminded not to see this list as covering all experiences that terrorist victims might express and that personal history, trauma history and cultural issues can influence reaction and healing (Nader and Danieli 2004; Thielman 2004).

Differences between victims of terrorism and other crime victims

There appears to be no research that specifically compares the differences in reactions between victims of terrorist attacks and other crime victims. From a clinical perspective, one can identify that the crime is the same – an assault, murder or rape is the same whether the perpetrator is motivated by political or other reasons. However, it is possible that the political nature of the crime may have an independent impact. Society's reaction and the perpetrator's motivation can cause additional distress (Herek et al. 1997; Herek et al. 1999; McDevitt et al. 2001). In a discussion focused on victim blaming, Shichor (2007) theorized that victims of terrorists could be seen by society as "more innocent" and thus be more likely to get support. However, he also noted that terrorist victims may also feel more helpless because they may feel they had less control over their victimization.

Trauma reactions do not follow a predictable path; each person is different (Silver et al. 2004). Many victims of terrorism may feel initial distress (Lahad 2005; Schlenger 2004), but do not go on to develop any major psychological problems (Fredrickson et al. 2003; Friedman 2005; Galili-Weisstub and Benarroch 2004). Some people may experience problems and not seek help because they believe they can get better on their own, don't want to appear weak or "crazy," or do not know where to find help, or they avoid treatment to stop thinking about the attack (Vardi 2005). Workers are encouraged to closely assess how victims handle the loss they have suffered and to monitor possible difficulties they have in making meaning from being a victim of a political crime.

Post-Traumatic Stress Reaction (PTSD) and Acute Stress Disorder (ASD)

By far the most researched issue among victims of terrorism is stress symptoms, from short-lived problems to full-blown clinical disorders (Amsel et al. 2005; Courtois 2004; Friedman 2005; Hall et al. 2004; Jehel and Brunet 2004; Khaled 2004; Neria et al. 2006; Office for Victims of Crime 2005; Ohtani et al. 2004; Pat-Horenczyk 2004; Pfefferbaum, et al. 2004; Silver et al. 2004; SAMHSA 2004; Somasundaram 2004). Post-Traumatic Stress Disorder is discussed in Chapter 4 of the original manual on common reactions to crime victimization. Acute Stress Disorder (ASD) is an anxiety disorder that is similar to PTSD in its symptoms but does not last as long; it is typically seen as the initial anxiety reaction to trauma (see Figure 2 in the *Common Reactions to Crime* section of the main manual). Note that these symptoms may shift back and forth; for example a victim may avoid the trauma at one point and relive it at others (Danieli et al. 2004).

Researchers in Israel followed survivors of a missile attack on a shopping mall and found that 24% showed symptoms of acute stress disorder (ASD) (Kutz and Dekel 2006). Those with ASD had a three times greater risk of developing PTSD. These same researchers found that roughly 25% of those exposed to a terrorist attack will develop PTSD (Kutz and Dekel 2006). For victims of ongoing terrorism, others report PTSD estimates as high as 40% (Jehel and Brunet 2004; Khaled 2004). Those who suffered directly from an attack and also dealt with changes in their daily living because of the attack (e.g. workplace or neighbourhood being bombed, daily living being affected by community changes) are at even higher risk of developing PTSD symptoms (Neria and Litz 2004). Neria et al. (2006) found that after 9/11, PTSD was more commonly seen in women, single people, immigrants, those with family histories of mental illness and those who were directly affected. Those victims that have PTSD show more fear of further terrorist attacks (Kutz and Dekel 2006), which likely interferes with their recovery. With victims traumatized to this extent, workers should seriously consider a referral to a mental health professional for ongoing treatment.

Green (1993) identified eight experiences that may place people at greater risk of developing PTSD:

1. Threat to life and limb
2. Severe physical injury
3. Being intentionally injured
4. Being exposed to awful or disgusting scenes
5. Violent or sudden loss of a loved one
6. Witnessing or learning of violence to a loved one
7. Learning of personal exposure to a noxious agent
8. Having caused the death or severe injury of another

Workers who encounter victims with stories containing these elements may want to watch for other signs of PTSD or refer the person to a mental health professional or family doctor for a more complete assessment.

Complicated grief

Several researchers have noted the complicated grief reaction seen in victims of terrorism who have lost a loved one (Freyd 2002; Malkinson et al. 2005; Neria et al. 2007; Pivar and Prigerson 2004; Raphael et al. 2004; SAMHSA 2004; Sofka 2004). In essence, the person is being challenged by both the loss of a loved one and the terrorist event itself (Malkinson et al. 2005). This is a very difficult situation for people to handle.

Some researchers hold that anger often interferes with healthy grieving (Lebel and Ronel 2005). Anger at the terrorists seems to be linked to wanting them to accept responsibility and declare their guilt, rather than revenge fantasies or other elements of anger (Lebel and Ronel 2005). This focus on responsibility may be similar to victims of any crime who seek justice and want their perpetrators to admit guilt. There is also some evidence of the direct link between terrorist attacks and subsequent hate crimes against members of communities similar to the perpetrators (Volpe and Strobl 2005). Workers should note that the perpetrators of these hate crimes are not necessarily those people who were direct or indirect victims of the terrorist attacks. It is very important for workers to understand the victim's anger as a normal reaction and work with him or her to help cope with the complex emotions and reactions they might experience (Dalenberg 2004).

Workers are reminded to pay close attention to cultural issues with respect to dealing with grief (Nordanger 2007). Workers should research the victim's culture to understand what normal grieving is within his or her home community. Nordanger found that Ethiopian victims grieving wartime losses tended to use avoidance techniques such as thinking about other things, distracting themselves or focusing on the future to deal with grief. In particular, they saw confronting or dwelling on loss as inviting other health, social/family or spiritual problems. Workers might also consider whether to encourage grieving victims to seek help from healers and spiritual advisors from their own community (Nordanger 2007).

Depression

Several researchers noted increased depression among survivors of terrorist attacks (Engdahl 2004; Gabriel et al. 2007; Khaled 2004; Miller and Heldring 2004; Neria et al. 2006; Neria et al. 2007; SAMHSA 2004; Schlenger 2004). Depression is described in Figure 3. In a sample of highly traumatized people who survived ongoing terrorist attacks, Khaled (2004) found that 23% were depressed. In samples of children and youth, however, researchers have found lower rates: 8% among children (Pfefferbaum et al. 2004) and about 15% among youth (Pat-Horenczyk 2004). It is interesting to note that there seems to be a delayed response with depression, typically peaking at roughly 6 months after the terrorist incident (Miller and Heldring 2004). Additionally, Neria et al. (2006) noted that victims of 9/11 were at higher risk of suicidal thoughts, especially if linked with other issues such as depression.

Survivor guilt

The issue of guilt in those who survive a terrorist attack appears in some reports (Danieli et al. 2004; Courtois 2004; SAMHSA 2004; Thielman 2004). This seems to be part of meaning-making, so the person not only wonders why they were a victim but also why they survived while others were injured or died. In particular, Thielman (2004) notes that there appear to be cultural differences in whether a person reports survivor guilt, but also recommends looking for depression when you encounter survivor guilt. Workers need to help victims of terrorism understand that survivor guilt is not an uncommon reaction. Furthermore, you can help victims make sense

of the attack, its impact on their life and get them to incorporate that knowledge into a future focus. Obviously, if this reaction is causing much distress, a referral to a mental health professional may also be helpful.

Reactions to being held hostage

Many terrorist groups will use hostage-taking as a method of exerting pressure. Hostages often feel helpless, hopeless, dazed, afraid of death or torture, in shock, and have distorted thoughts and feelings (Hillman 1983). Hillman (1983) also described a state of "learned helplessness," where the hostage begins to do whatever is asked, without question. Turner (1985) speaks of the hostage moving from feeling fearful and confused to having feelings of isolation and boredom, asking "why me", reviewing his life, making up rituals and planning for the future. Frankly (1963), a psychiatrist who survived Nazi concentration camps, would argue that it is this "future focus" and surviving for something greater than oneself (such as family, work, spirituality) that helps some people survive being held captive.

Another issue for hostages is the possible development of Stockholm Syndrome, also know as Hostage Identification Syndrome (HIS). This is a condition wherein a hostage bonds with the hostage-taker during the holding phase of the crime (Wilson 2003). Turner (1985) identified several factors that seem to increase the chances of HIS: face-to-face contact, shared language, previously held beliefs or sympathies, and length of captivity. The bond is less likely if the victim is aware of the risk of HIS or if there is unnecessary violence. Workers may need to seek consultation or refer clients to mental health professionals if they feel the victim is struggling with these types of issues.

Special Issue: Child Victims

How children cope with terrorist attacks has received some attention in the research literature (Campbell et al. 2004; Courtois 2004; Galili-Weisstub and Benarroch 2004; Joshi and O'Donnell 2003; Kaplan et al. 2005; Nielsen et al. 2006; Pat-Horenczyk 2004; Pfefferbaum et al. 2004). Children can be direct victims, indirect victims, or even members of the community who witness the event on television. Joshi and O'Donnell (2003) point out that children exposed to trauma can develop behaviour problems, aggression, emotional difficulties, mental health problems, academic problems, and become socially withdrawn. Others have also pointed to behaviour problems in youths exposed to terrorist attacks (Campbell et al. 2004). Courtois (2004) also points out that children may be more prone to dissociation[12] than adults. Similar to adults, those children who were direct victims are more likely to show more severe symptoms (Pfefferbaum, et al. 2004). Workers need to be aware that children may have difficulty directly communicating why they are having problems, so it is important to be watchful for these behaviours. Therefore, there are special issues that should be noted when dealing with this group that may be best addressed by mental health professionals or colleagues with experience in working with children.

12 Dissociation is a clinical term similar to what people call "shock". Often the person has a break in his normal way of thinking, memory, identity or view of the environment.

Table T1: Common reactions of children by age

Young Children	School-Aged Children	Adolescents
■ Helplessness and passivity ■ Heightened arousal and agitation ■ Generalized fears and anxieties ■ Cognitive confusion ■ Inability to comprehend and talk about event or feelings ■ Sleep disturbances, nightmares ■ Anxious attachment, clinging ■ Regressive symptoms ■ Unable to understand death as permanent ■ Grief related to abandonment of caregiver ■ Somatic symptoms	■ Responsibility and guilt ■ Repetitious traumatic play and re-telling ■ Reminders trigger disturbing feelings ■ Sleep disturbances, nightmares ■ Safety concerns, preoccupation with danger ■ Aggressive behaviour, angry outbursts ■ Irrational fears and traumatic reactions ■ Close attention to parental anxieties and reactions ■ Preoccupation with "mechanisms" of death ■ Concentration and learning problems ■ School avoidance ■ Worry and concern for others	■ Shame, guilt, humiliation ■ Self-consciousness ■ Post-traumatic acting out ■ Life-threatening re-enactment ■ Rebellion at home or school ■ Abrupt shift in relationships ■ Depression, social withdrawal ■ Decline in school performance ■ Desire for revenge ■ Radical change in attitude ■ Premature entrance into adulthood ■ Detachment from feelings

Developmental level

Although there is debate about which age group is most likely to develop problems after a terrorist attack (Pat-Horenczyk 2004), a child's age and other developmental issues are important to look at when working with child victims. Galili-Weisstub and Benarroch (2004) point out caregiver reaction can have a direct impact on very young children (under two years old). Preschoolers are also affected by caregiver reaction, but are able to ask questions and talk about their reaction. With preschoolers one might also want to watch for other signs of distress such as excessive clinginess, emotional outbursts and irritability, behaviour shifts or even returning to behaviour they had outgrown (Kaplan et al. 2005). School-aged children may tend to show sleep difficulties, problems at school and

other more behavioural problems (Kaplan et al. 2005). As with the other younger groups, parental reaction and modeling appears to affect school-aged children as well.

Finally, adolescents seem to have a greater sensitivity to trauma reaction, perhaps related to the conflict between wanting to be an independent person and still needing support because of the trauma (Kaplan et al. 2005). Adolescents have shown increased fear (Addington 2003; Ronen et al. 2003) and nightmares after an attack. More concerning is that this effect is seen even two years after the event (Nielsen et al. 2006). Table T1 was developed with information taken from an excellent resource (*Mental health response to mass violence and terrorism: A training manual* SAMHSA 2004) and may be of help to workers wanting a summary. Note that children can experience many of the same reactions as adults when faced with trauma.

Caregiver reaction

Often parents and other caregivers will want advice on how to talk to children about the terrorist attack (Miller and Heldring 2004). As noted above, caregiver reaction can have a positive or negative impact on children (Galili-Weisstub and Benarroch 2004). Caregivers not only model how to emotionally handle victimization, they also help the child to better manage her reaction to the attack. Workers can teach parents what signs might be related to trauma or other reactions to terrorist attacks, such as those listed above. Caregivers need to reassure children that they are safe and they need to be able to listen to their children's concerns. Professionals or paraprofessionals used to working with children may also be needed to help the child feel safe, understand and accept the attack, work through issues and cope effectively to return to normal age-appropriate activities and daily living (SAMHSA 2004). Caregivers themselves may need support to deal with their reactions while creating a home life that is healing (SAMHSA 2004).

Clinical Issues

As Neria and Litz, (2004) indicate, the victims of terrorism need to rebuild their lives and reconnect to feelings of safety, comfort, and protection in order to recover. Workers can help victims of terrorism reach this goal. As with other crime victims, this is not a matter of returning to a pre-crime state, but, rather, fitting the experience into

their new reality (Casarez-Levison 1992). Stage of recovery, trauma prevention strategies, meaning-making, trauma history, identification of strengths, and accessing support all influence the victim's recovery process.

Stages of recovery

We can view victims of terrorism, like other crime victims, as moving from a previctimization status to victimization, transition and, eventually, reorganization (Casarez-Levison 1992). Workers may want to refer to earlier chapters to help match victims to key services. Initially, the victim might require practical support (housing, food, medical attention, etc.), crisis intervention, short-term emotional support, information, and so forth. Further along the recovery path, there may be more need for meaning-making efforts or grief counselling. In other words, workers need to attend to their assessment of the victim, matching interventions to identified needs.

Trauma-prevention strategies

International and local businesses have been employing staff training around dealing with traumatic events (e.g. hostage taking) as a way to inoculate their staff in the event of a terrorist activity. Given the wide range of possible reactions it is challenging to fully prepare people for the chaos (Hall et al. 2004). However, the public expects government and community organizations to have a clear and effective plan (Lahad 2005; Laor et al. 2005). Similarly, several authors note that the media can be used to help the public at large understand what has happened and what to do (Durodié and Wessely 2002; Reyes and Elhai 2004; Ross 2004; Thielman 2004). Since this public health approach uses the same method of service delivery as the terrorists use to spread fear, it should reach much the same audience (Ross 2004; Thielman 2004).

Meaning-making: Telling the story

Recall the model in Part One and the fact that crime victims need to understand and make meaning from what has happened. Successful meaning-making among victims of terrorism can result in increased appreciation for life, a reorganization of their priorities, and a realization that they are stronger than they had thought (Danieli et al. 2004; Frankl 1963). Through telling their story, the terrorist victim can begin to make sense, in a controlled way, of what has happened (Kutz and Bleich 2005) and also reinterpret the situation (Adessky and

Freedman 2005). Unlike uncontrolled reliving of the event, the retelling helps regain a sense of mastery over their life (Amsel et al. 2005; Kutz and Bleich 2005).

Meaning-making: Allowing emotion

It is important for all crime victims to be able to express their feelings in an open manner. The victim might express anger, sadness, hopelessness, or any range of emotions and the role of the worker is to allow this expression but also to help to make meaning (Kutz and Bleich 2005). Note that trauma victims may receive both direct and indirect messages from people in their lives that they should not express their feelings and emotions (Danieli et al. 2004). Thus, it becomes even more important to provide an environment that encourages and supports such sharing.

Trauma history and re-traumatization

Workers also need to be aware of two aspects of trauma with victims of terrorism: previous trauma and repeat trauma (Adessky and Freedman 2005). First, 9/11 had the strongest impact on people who had a history of trauma (Danieli et al. 2004; Neria et al. 2006; SAMHSA 2004). Thus, in seeing a more severe reaction, workers may want to get a trauma history from the person since only some of the current symptoms and issues may be related to the terrorist attack. Second, once traumatized, the person is more vulnerable to re-traumatization by other events (Kinzie 2004). During this confusing and sensitive time the victim can be quite vulnerable. Of particular note, watching television coverage related to the terrorist event can have a negative effect on the trauma reaction of both adults and children (Delahanty 2007; Miller and Heldring 2004).

Identification of strengths

Many researchers and clinicians focus on strengths shown during and after the terrorist attacks (Danieli et al. 2004; Fredrickson et al. 2003; Raphael et al. 2004). Some talk about the natural "heroic period" that occurs during the attack, when strangers risk themselves for victims and a honeymoon period characterized by kindness and generosity (Reissman et al. 2005). Others point to resiliency in coping with the attack, as well as, meeting the needs of the victims and community (Fredrickson et al. 2003; Friedman 2005; Danieli et al. 2004; Heldring

and Kudler 2005; Raphael et al. 2004; Ross 2004; SAMHSA 2004; Sederer et al. 2005). Peterson (2002 cited in Danieli, Brom and Sills 2004) used the Internet to examine Americans' values, strengths, and virtues before and after 9/11 and found an increase in levels of love, gratitude, hope, kindness, spirituality, and teamwork. Spirituality, either through participating in religious activities or more private approaches, is often mentioned as a major coping strategy in dealing with terrorist attacks (Berger 2005; Nader and Danieli 2004; Pat-Horenczyk 2004; Sofka 2004; Thielman 2004; Yeh et al. 2006). Workers should be respectful of the victims' personal choices and offer help by finding appropriate ways for them to access their strengths.

Support networks

As noted earlier, victimization occurs on a continuum. The victim of a terrorist hostage taking may be seen as a primary victim. However, the victim's family, friends, community, and helping professionals are also victims of the terrorist attack to different degrees. This becomes very important when looking at the victim's support networks, since this is where the victim often turns first when they need help. Research shows that seeking support is a successful coping strategy to address ongoing distress (Miller and Heldring 2004). There is a consensus that most victims of terrorist attacks do not seek professional help for psychological reactions to terrorist attacks (Adams et al. 2004; Ben-Gershon et al. 2005; Neria 2005; Raphael et al. 2004).

Victims prefer not to talk to professionals, but rather to rely on their natural support network (Leymann and Lindell 1992). Canadian statistics indicate that crime victims sought assistance from a formal help agency (victim services, crisis centres, help lines, health or social services) in 9% of incidents; the rest (90%) relied on their natural support network (Gannon and Mihorean 2005). The stress of helping the victim cope can become overwhelming (Mikulincer et al. 1993; Nolen-Hoeksema and Davis 1999). Furthermore, natural supports themselves may be struggling with the terrorist attack and not be as helpful or available (SAMHSA 2004). Thus, workers may find that they are working with an identified victim, but have many other victims in the background, struggling with issues. This may require working with many people and you as the worker taking a variety of supportive roles (e.g. emotional, appraisal, informational, instrumental; Table 4, page 26 of the original manual).

Provider Issues

Self-care for those working with victims of crime is exceptionally important, as discussed in Chapter One. After a terrorist attack, self-care habits are even more important because of the initial crisis atmosphere and later service needs (Waizer et al. 2004). Many professionals report having trouble coping with their reactions to terrorist attacks (Colarossi et al. 2005; Shamai 2005), thus there are additional self-care-related issues that one should consider when working with victims of terrorism. Recognizing early symptoms of distress, talking to others, recognizing your skills and limitations, building personal resources and building an acceptance of the difficulty of the work are all important (Danieli 2005). This section focuses on key areas for workers to understand when working with victims of terrorism.

Personal views

Although this may be a difficult issue for some to grasp, all those working with victims of terrorism need to examine their views on the political goals of the terrorists. As a person who works with victims, there is little doubt that you have empathy for the victim and a negative reaction to the criminal. However, in the case of terrorism you may find that even though you do not agree with the use of violence, you may be sympathetic to the terrorists' cause. On the other hand, you may disagree with both their actions and their goals. Either way, these personal feelings may influence your work with victims. Furthermore, you may have strong views, either positive or negative about the reaction of other authorities or governments to the terrorist attack. The political nature of terrorism makes it much more complicated to process. Your role is to help the victim deal with being victimized. Ignoring your own personal reaction to the efforts of terrorists (not their actions), however, could interfere with your effectiveness. Thus, you may want to use supervision, consultation, discussion groups/ workshops or keeping a journal to process these reactions and set clear boundaries.

Vicarious traumatization

Like other crimes, the violation associated with terrorism can have a profound impact on you as a worker. You need to assess your own reaction: Are you having intrusive thoughts or images, or spending much time thinking about the victim's ordeal? You may want to explore

the personal impact of the terrorist attack on your own life (Danieli 2005). Depending on the nature of the terrorist attack, you may be dealing with a mass tragedy or ongoing incidents, which can create vicarious trauma (Fraidlin and Rabin 2006). You can discuss these issues on teams, in consultation or supervision. If you feel your reaction is interfering with your ability to do good work, then it makes sense to seek therapy to deal with these feelings.

Acceptance

Danieli (2005) noted that to heal and grow we need to accept that our lives will not be the same. This "new normal" impacts all parts of our lives: victims, workers and society (Danieli et al. 2004). As those who work with people experiencing distress from a traumatic event (crime or otherwise), we see many people dealing with challenges to their view of a safe and just world. The "new normal" also impacts you and as you come to accept the new reality, you can help your clients accept it as well. Of importance, acceptance does not mean you cannot improve the "new normal." In fact, helping victims of terrorism improves the "new normal" one person, family or group at a time.

Web-based Resources

There is much on the World Wide Web that you can use to learn more about working with victims of terrorism. Using any search engine will take you to useful resources. The following sites are identified as ways of quickly getting useful information. You are encouraged to do your own search, focusing on issues specific to the needs of your client.

The **American Psychology Association (APA)** has developed facts sheets designed to help build resilience in a variety of populations after terrorist attacks, including adults, children, first responders, mental health workers, military families, older adults, people of colour, primary care providers, and the seriously mentally ill.
http://www.apa.org/psychologists/resilience.html

The **Canadian Psychology Association (CPA)** has developed facts sheets around various problems areas, including post-traumatic stress disorder, grief and depression.
http://www.cpa.ca/publications/yourhealthpsychologyworksfactsheets/

Facing fear together is a Web site focused on mental health and primary care organizations that deal with terrorism.
http://www.facingfeartogether.org/healthtogether/facingfear/

The **International Society for Traumatic Stress Studies (ISTSS)** is an international multidisciplinary, professional organization that focuses on severe stress and trauma. The organization explores issues such as understanding the scope and consequences of traumatic exposure, preventing traumatic events and ameliorating their consequences, and advocating for the field of traumatic stress. Their site includes a sub-section on terrorism, including links and pamphlets.
http://www.istss.org/terrorism/professionals.htm

The **Memorial Institute for the Prevention of Terrorism (MIPT)** has a large database of articles and information around all aspects of terrorism, including links to other sites.
http://www.mipt.org/

The **Office for Victims of Crime Resource Center (OVCRC)** has a searchable archive on various victims' issues and several manuals and reports that were used in this chapter.
http://www.ojp.usdoj.gov/ovc/

Victims Assistance Online is an information, research and networking resource focused on victimology for victim assistance workers and professionals working with victims. They have a special page for victims of terrorism.
http://www.vaonline.org/terrorism.html

The Basics

- Terrorists use violent criminal behaviour to meet political ends by putting pressure on decision makers and society (Ganor 2004). By focusing on political leaders and general community members, terrorists spread fear throughout society to increase attention to their political cause (Danieli, Brom and Sills 2004).
- Terrorism strikes at the heart of viewing the world as a safe and predictable place (Davidowitz-Farkas and Hutchison-Hall 2005).
- Victims of terrorism include:
  - *Direct victims*: those killed or who directly witnessed the attack.

  - *Direct professional/volunteer victims*: includes people who are at the scene of the terrorist attack as part of their job or as volunteers.
  - *Indirect victims*: direct victims family members, friends, co-workers, etc. Direct victims often use this group for support.
  - *Community victims*: people in the community who are affected by the attack.
  - *Re-victimized victims*: people who have been victims of previous terrorist attacks, but are now re-traumatized by a new attack or report of a thwarted attack.
- There appears to be no research directly comparing victims of terrorism with other crime victims.
- Trauma reactions do not follow a predictable path; each person is different (Silver et al. 2004).
- Many victims of terrorism may feel initial distress (Lahad 2005; Schlenger 2004) but not go on to develop any major psychological problems (Friedman 2005; Galili-Weisstub and Benarroch 2004).
- Problems workers should watch for in their clients include Post-Traumatic Stress Reaction and Acute Stress Disorder (Office for Victims of Crime 2005); complicated grief (Pivar and Prigerson 2004); and anger (Lebel and Ronel 2005), depression (Miller and Heldring 2004), survivor guilt.
- Victims who have been held hostage may experience feelings of helplessness, hopelessness, may feel dazed, fear death/torture, be in shock, and have distorted thoughts and feelings (Hillman 1983) and can also develop Stockholm Syndrome. Stockholm Syndrome (also know as Hostage Identification Syndrome) is a condition wherein a hostage bonds with the hostage taker during the holding phase of the crime (Wilson 2003).
- Child victims of terrorism deal with many of the same issues as adults do, but much more depends on caregiver reaction and developmental level. Caregivers need to model how to emotionally handle victimization; they also help children better manage reactions.
- Workers need to assess whether victims need crisis intervention, short-term emotional support, information, support in their meaning-making efforts, or grief counselling.
- Meaning-making includes both allowing the victim to create a manageable story while also express feelings in an open manner.

- Workers should also attend to trauma histories, as a previous history of trauma can worsen reactions to the most recent event.
- Workers should help victims identify strengths that help them cope with their reaction, and watch for post-traumatic growth, where the person improves because of successfully overcoming the challenge of the attack.
- Workers may need to provide or offer guidance and assistance to the victim's support network.
- Workers should remember that self-care habits are even more important because of the initial crisis atmosphere and later service needs (Waizer et al. 2004).
- Workers need to pay attention to their personal views about the terrorist attack and the agenda and reaction of other governments, as these views may affect their work.
- Workers need to watch for vicarious traumatization, for intrusive thoughts and images, and signs they are spending much time thinking about the victim's ordeal.
- Workers need to adjust to the "new normal" (Danieli et al. 2004).

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