Working with Victims of Crime:
A Manual Applying Research
to Clinical Practice

Working with Victims of Crime: A Manual Applying Research to Clinical Practice

Manual

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March 31, 2004

The views expressed in this report are those of the author and do not necessarily represent the views of the Department of Justice Canada.

Preface

How can I help this crime victim get on with her life? What do I say to the parents of the missing child? What do I do with the explosions of anger? Does it really help if I just listen? When does it get better? These are a few of the questions I hear regularly from people who are dealing with victims of serious crime. They are good questions that come from a place of caring as well as frustration and confusion. This manual provides a place to explore some of the answers to these basic questions.

It must be over a decade now since I began my research into crime victimization. In one of the first articles that I uncovered, I read that most counselors found victims of serious crime difficult to work with and because of this they were often avoided by seasoned counselors. I took it personally. I couldn't believe that we who had experienced a violent crime were in some ways being rejected by a group whom we believed had the ability to help us. I shouldn't have been surprised. Even the ancient, well-known story of the Good Samaritan in the Bible is about a crime victim being passed over, neglected, avoided and ignored.

Over time, I've come to understand what that psychologist author meant about the difficulty of dealing with crime victims. They are a clientele who are often characterized by uncontrollable anger, disorganization, unpredictability, and extreme traumatization. To work with crime victims requires an immense amount of patience, courage and a deep sense of "knowing" and understanding the experience of crime victimization. It can be extremely demanding. It is no wonder dedicated front-line service providers are often tired and burned out.

But in spite of the hardships, there are many service providers who have survived in this field and remain important support for many crime victims. They share a few characteristics. While they remain warm and supportive, they don't promise to do anything they can't deliver. They are knowledgeable about the trauma of crime and respect the devastation it creates. They remain loyal to the victims but change their roles as the victims heal and change themselves. They are in there for the long haul. Humble in their ability, but faithful in their effort. They are also always looking for new material that will help them add to their knowledge.

This manual, I am sure will become part of their valuable collection. It provides a comprehensive framework for the research that is now surfacing in the field. By beginning with the needs of the service provider for self-care, this work shows itself to be sensitive to the human need of the crime victim as well. Well outlined and organized, it gives a good overview of the psychological change that happens in crime victims. It also outlines the common coping strategies of victims, negative and positive, and ends with suggestions. The comprehensive bibliography grounds the work on a solid research basis.

Service providers who are looking to sharpen their tools to do their work more effectively will find this manual helpful in honing their skills.

Wilma Derksen
Director of Victims' Voice
Mennonite Central Committee Canada

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 impacts 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.

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Acknowledgements

The author would like to gratefully acknowledge Susan McDonald PhD., Lara Rooney, Dr. Lara Robinson and members of the Federal/Provincial/Territorial Victims of Crime Working Group (FPTWG) for their helpful comments on earlier drafts of this manual.

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Introduction

This manual is mainly designed for those who deliver front-line services to crime victims. This quick reference resource should help front-line workers to 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. 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 is set up to focus on how research findings might be linked to skills development. Each section focuses on common experiences of crime victims and other important issues. "The Importance of Self-Care" section focuses on advice to workers in taking care of themselves as they work within this challenging and rewarding area. The "Model of Victimization and Recovery" section 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 reaction severity. The next section, "How Do Victims Cope?" focuses on coping strategies often used by victims and the issue of self-efficacy. The "A Model for Client Change: The Stages of Change" section presents the Transtheoretical Model of Change (Prochaska, DiClemente & Norcross, 1992) and describes how it might be used to help victims to increase their motivation in getting help. Finally, the "Pulling it Together: Concluding Remarks" section 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 sheet 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.

Throughout this manual, a crime victim will 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 loved-ones and support people to the victim). These people may also suffer psychologically, socially or financially and may deal with many of the same issues as the victim. The clinical skills and information provided in the manual may be of help to these potential supports as well.

Finally, a quick note on pronoun use: to avoid the cumbersome use of "he or she", the manual text will alternate between the use of "he" and "she".

2.0 The Importance of Self-Care

2.1 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. The author disagrees 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.

Although it goes without saying that working with victims can be stressful, some researchers have looked at this issue. 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 both victim behaviour and perpetrators. Added challenges of the job include stress related to time pressures, red tape, physical demands and lack of achievement (Brown & O'Brien, 1998). Thus, these researchers found that job stress is not only related to the clients, but also to dealing with the system. This is likely not very surprising to workers. However, this point is important to emphasize 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 war-related trauma victims. They compared this group with therapists from general therapy settings and group homes. They found that therapists who worked with trauma victims reported being less objective, 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, more bored and reported less anxiety and reservation (Holmqvist & Andersen, 2003). Perhaps as the therapists become more detached they were better able to deal with the anxiety related to their work. Holmqvist and Andersen (2003) emphasized the importance of therapist self-care and noted the danger that distancing could interfere with good clinical work.

Self-care is important; our self-care activities, however, can have positive or negative effects depending on what self-care activities we use. Passive methods such as avoidance, ignoring the stress source or using alcohol or drugs are not the best way of dealing with the stress because they do nothing to address the underlying problem (Pines & Aronson, 1988). 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 more 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 & Aronson, 1988). These researchers also found that workers who have a positive attitude also show less career burnout.

Another important issue in self-care is balancing home and work life. A later section will discuss building a balanced life. However, workers should also keep in mind that 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.

2.2 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 areas are possible ways that workers can seek balance. This 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

As a beginning of understanding our stress levels, we should continually assess and examine our feelings, thoughts and behaviour (Grosch & 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 may appear as not feeling rested after sleep, losing energy quickly, feeling frustrated, feeling empty and "wrung-out" (Grosch & Olsen, 1994; Pines & Aronson, 1988). Needless to say, these 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 better cope. As workers we need to listen closely to our bodies, feelings and thoughts, but also listen closely to feedback from others. Listening to co-workers, friends and family can be a good way to keep track of our 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) 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 & 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 & O'Brien, 1998). As workers, we need to build a support network that helps support us and from whom we can receive clear, direct feedback. Building a network of support that tiptoes around us, or treats us like a delicate glass figurine, will not help if we need clear feedback. Remember--- this may include feedback from friends and family, because they may be in the best position to 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 & Olsen, 1994; Kottler, 1999). Anyone working in the 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. Remember--- setting strong boundaries does not mean that we cannot be adaptable. Workers simply need to be aware of our 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, 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 is: "Do my boundaries help me build and keep resources to the benefit of myself and my clients?" By always putting our needs last, we risk becoming less effective as a worker and person.

Building a balanced life

This element is closely related to setting boundaries (Grosch & Olsen, 1994). The reason people discuss a balanced life and setting limits so much is that 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 is "no big deal", because that's when the client can meet. 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 our 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. Remember--- 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, etc.) then we may be less likely to try to get 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 her roles in order of importance and set aside time for those things she feels are 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 baseball, meditating, golfing, painting or whatever we like to do to recharge. It can be useful to write out a "Recharge List" of things that help us unwind. Keep it handy so that when we feel tense or overwhelmed, we can quickly look at the list and do something on it that will help us take a breather.

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

Education and professional development

Workers can always benefit from professional development and training. These activities not only teach new skills, but also give time for workers to reflect on their performance. In other words, these activities sharpen our skills (axe) by taking time to reflect (noticing the dullness) and add or improve 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 with a new vantage point can help recharge the worker in providing services. In a sense, setting aside time to read this manual is self-care.

Services for workers

Workers also need to learn 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 & Olsen, 1994; Kottler, 1999). Basically, these direct methods of dealing with stress help workers 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, it may be important to deal with past issues at a deep level, so therapy may be the best approach. However, we may just need a place to "unload" our stress, thus 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 things 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 used for one key reason: working with people in distress is a highly stressful and highly rewarding activity (Grosch & Olsen, 1994; Pines &

Aronson, 1988). Workers should not ignore the rewards of this work, but these benefits can only be felt if we feel healthy (Kottler, 1999). 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 that we can handle everything. This may be an expectation we have of ourselves, or it may become part of the culture in the helping agency. Such views are tempting because the work is very important.

Some view working with victims as a "calling" wherein we silently shoulder the stress. This view 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.

2.3 Further Reading in Self-Care

Self-care activities are important. This is a manual on crime victims, not workers, and so self-care activities are only briefly introduced in the above section. Interested readers are directed to the following resources and websites 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 the publication:

Richardson, J. I. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers*. Ottawa, ON: Health Canada.
Web link: www.hc-sc.gc.ca/hppb/familyviolence/pdfs/trauma_e.pdf.

The following resources can 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 has a selected bibliography on the web at: www.isu.edu/~bhstamm/ts/vt.htm

National Center for Post-Traumatic Stress Disorder: www.ncptsd.org

National Family Violence Clearinghouse, Health Canada: www.hc-sc.gc.ca/hppb/familyviolence

2.4 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 and strength (Grosch & Olsen, 1994; Kottler, 1999).
  - Use of effective supervision from superiors and peer support from co-workers (Grosch & Olsen, 1994; Kottler, 1999).
  - Setting boundaries, both in your work and home life (Grosch & Olsen, 1994).
  - Building a balanced life (Grosch & Olsen, 1994).
  - Using support groups, therapy, outpatient treatment, etc. (Grosch & Olsen, 1994).
  - Education and professional development.

- Spend time reading on self-care and try some of the activities suggested.

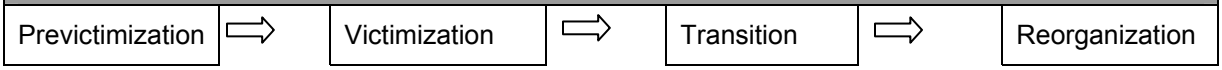
… Sharpen your axe

3.0 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. From this view, victimization includes how the person deals with the stress of being victimized by something beyond his control. Before discussing the theories and research looking at victims, a key point needs to be highlighted: All crime victims are not 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 very 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 psychologically change as they are faced with a criminal event and begin to identify themselves as a "crime victim". 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 precrime 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. She has a life history, strengths and weaknesses, a support system, financial pressures and so on. This includes her history of previous victimization, trauma and coping. This point is key since research shows that current victims of crime often have a history of previous victimization (Byrne, Resnick, Kilpatrick, Best & Saunders, 1999; Messman & Long, 1996; Norris, Kaniasty, & Thompson, 1997; Nishith, Mechanic & Resick, 2000). This is important information for workers to know because how a person has dealt with previous victimizations may give clues about how 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, Boyer, Weiss & Marmar, 2001).

The crime: Victimization/disorganization

The person is now faced with the crime. This might include walking in to find that her home has been burgled, being assaulted while walking home from the gym, etc. This stage may continue

for a few hours or days as she 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 the crime?
3) How will I deal with the crime and my victimization?

The victim will base decisions on her previous experiences, current level of emotional distress and knowledge about options. 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 (do nothing, notify police, re-evaluate the situation or seek a private solution). 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 & Ruback, 1992), even the perpetrator can sway her decisions. Thus, workers could meet victims who are experiencing severe reactions weeks, months or even years after the event (Thompson, 2000) and may not be aware that their problems relate to the victimization.

Given that victims are often the people who report the crime, these decisions can be crucial in how they deal with their distress. Research on crime reporting reflects these different decision-making processes (Greenberg & Ruback, 1992). The type of crime and situation issues are key to 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), and thus 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, Viki, Masser & Bohner, 2003), which likely affects the victim's willingness to report the crime. These results will not surprise most workers working with victims of domestic violence or date rape.

Once the person begins to identify herself as a crime victim, assuming the person is a victim, she will now follow a relatively unique coping and decision-making path based on her precrime status (as stated above). However, she is likely to feel threatened, confused, helpless, angry, numb or fearful. She 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 whatever skills and abilities she has (Casarez-Levison, 1992).

Initial coping: Transition / protection

After the initial reaction, the person is then left to adjust to the long-term effects of the crime. This adjustment can start within a few weeks of the crime to 6 to 8 months later. This stage is similar to the previous stage, but now the victim is beginning the process of putting her life back together. Basically, she has started to make sense of her victimization (meaning-making). Meaning making has often been seen as a part of grief work (Davis, Nolen-Hoeksema & Larson, 1998), a spiritual element of coping (Cadell, Regehr & Hemsworth, 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 in dealing with any type of trauma (Nolen-Hoeksema & Davis, 1999). In fact, it is often included as a major element in treatment interventions (Foy, Eriksson & Trice, 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 victim better deal with stress, get information and improve his attempts to cope. Respect, honesty and trust build emotional engagement, the basis of a good helping relationship. Emotionally engaged clients recover faster (Gilboa-Schechtman & Foa, 2001). To be respectful of clients, workers should ensure that victims understand that treatment may mean getting worse before getting better (Nishith, Resick & Griffin, 2002). Workers should also be watchful of 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 are hiding deep problems under a calm exterior.

Given the above discussion, workers need to be wary of a "trauma bias" where one assumes that crime victims are automatically traumatized when they are not (Nelson, Wangsgaard, Yorgason, Higgins Kessler & Carter-Vassol, 2002). Workers should remain sensitive to the possibility that certain victims may be hiding trauma while others are actually coping well. Respecting the victim means that you must trust his self-assessment of his 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. This helps the person rebuild his life and move forward. However, if not handled well, he is unlikely to fully move into the final stage and may even reach a state of total exhaustion (Casarez-Levison, 1992).

Moving forward: Reorganization/resolution

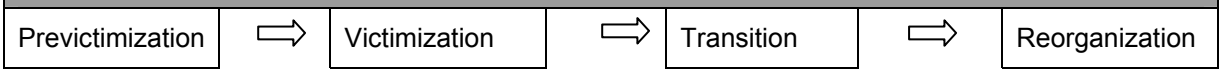
This period focuses on the victim rebuilding herself into a stable functioning person who is doing well and has normal relationships. In the best case, this may occur in 6 to 12 months; in the worst case, the process can take many years (Casarez-Levison, 1992). Most people will face feelings of denial and acceptance around their experience. Workers will often find that the victim asks questions about the world being a safe place, her new "survivor" role, and linking her new experiences with her pre-victim characteristics. Workers and victims need to understand that this rebuilding does not mean returning to "the past", as though the crime did not occur. Being victimized changes how the person views herself and the world and this makes it very unlikely that she will return to "precrime normal" (Norris et al., 1997). The person needs to understand the crime as something that happened and put it together with her understanding of her world. Workers should address poor responses, such as substance abuse and mental health problems as soon as possible as these behaviours 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 post-victimization (Resick, Nishith, Weaver, Astin & Feuer, 2002).

3.1 The Basics…

- Casarez-Levison (1992) discussed victimization as a process where the person moves from a precrime 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 their life experience (Resolution).

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



- Victims do not return to a pre-crime state---that is, victims need to make sense of the crime and its effects and this becomes part of their life experience (Norris et al., 1997).
- Workers should ensure that victims understand that treatment may mean getting worse before getting better (Nishith, Resick & Griffin, 2002).
- Workers should also 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.
- Interventions appear to be able to help victims many years post-victimization (Resick, Nishith, Weaver, Astin & Feuer, 2002).
- Workers need to be cautious of engaging in "trauma bias" where one assumes that crime victims are automatically traumatized when they are not (Nelson, Wangsgaard, Yorgason, Higgins Kessler & Carter-Vassol, 2002).

4.0 Common Reactions to Crime

It is useful to know common reactions that victims may face when trying to cope with the crime. Recall, that each victim will have his own unique path towards recovery, but workers should be aware of common reactions to help them better help victims recover. About 25% of violent crime victims 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 violent crime victims report moderate to extreme distress. In order to help us understand the type of reactions we might encounter when working with victims, Table 1 shows the reactions that researchers and theoreticians have observed in crime victims. However, workers may also recognize these reactions in the victim's friends and family. The crime affects family and friends, school, work and the broader community (Burlingame & Layne, 2001).

Table 1: Common reactions to crime victimization

Mood/Emotions	Social	Thinking/ Memories	Physical
Fear/phobias [1, 3, 4, 5] Anger/hostility [1, 2, 3, 4, 7] Embarrassment [1] Anxiety [2, 5, 7] Depression [2, 4, 6] Grief [1, 2, 4] Guilt/shame [4, 5, 6] Difficulty controlling emotions [4] Apathy [5] Lower self-esteem [7]	Changes in relating to people [2, 6] Avoidance [5, 7] Alienation [5]	Intrusive memories [2] Lower self-efficacy [2] Vigilance [2] Flashbacks [5] Confusion/poor concentration [4, 5] Dissociation [4]	Nausea[1] Stomach problems [1] Muscle tension [1] Sleep problems [2]

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

Of note, the issue of anger as a reaction is more complicated than one might first assume. Researchers often link anger to property crime and fear to violent crime (Greenberg & Ruback, 1992). However, anger is basically a reaction wherein the person feels cheated out of something she felt she deserved. In the case of criminal victimization, she has been cheated out of her 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) pointed out that many victims create internal fantasies about getting revenge or justice. If these fantasies have positive outcomes (e.g., the perpetrator is caught), it may increase the chance the victim will take action. Thus, so-called "righteous anger" can help the person move forward, helping to energize her to deal with the criminal justice system or get help. Under this view, anger management programs may do a disservice to victims.

Having said this, workers need to be careful of confusing anger with empowerment. If not handled properly, chronic anger can be very harmful to the victim. Each victim must be treated as an individual. Workers should help her learn to manage all emotions in a way that helps her cope with challenges while remaining healthy. This will help the victim move forward and rebuild her life. 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.

4.1 Severity of Reaction

Severe reactions can be overwhelming to workers. As reactions become less severe, they do not necessarily become easier for the victim. This mismatch poses a challenge to both workers and victims. Norris et al.'s (1997) research indicated that violence during the crime increases response severity; victims of non-violent crime, however, also fear for their safety and can have increased psychological symptoms. Although there was 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 how to work with clients. Thus, a victim of a violent crime that reports that he feels no distress may need closer monitoring. His statement should be examined in relation to his coping skills, current behaviour and life experience. Workers need to work with the client to help him understand his distress levels and how the crime has affected his life.

The victim is the best source of information about what is happening in his life. Recall that research has shown that around 50% of violent crime victims experience moderate to severe distress (Norris et al., 1997). This also means that around 50% of victims do not experience these higher levels of distress. Research on sexual assault victims found that they experience more severe reactions and took longer to heal than non-sexual assault victims (Gilboa-Schechtman & Foa, 2001). Both groups had similar post-traumatic stress disorder (PTSD) and anxiety levels, but the sexual assault group showed higher levels of depression.

Of possible importance to workers, Gilboa-Schechtman and Foa (2001) also examined "peak reactions". Peak reactions refer to the point at which the victim experiences the strongest symptoms. They found that the longer the person 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 if seen 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 & 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 a **very** 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, both related to sexual assault: 1) those reporting primarily sexual assault and, 2) those reporting repeated violence that included sexual violence. Both of these groups would likely experience severe reactions. This research likely 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 & 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 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 proposed 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.

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.
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 and display 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.

Secondary victimization

Secondary victimization is related to severity as it can worsen an already difficult situation. Basically this happens when the person comes into contact with professionals and paraprofessionals and is further traumatized by their response. This can happen through retelling her story, being treated unfairly or experiencing other behaviours that make her feel as though people aren't listening or don't believe her. It is noteworthy that when victims described police as "helpful" they felt more connected to others (Norris et al., 1997). However, negative experiences with professionals increased post-traumatic stress symptoms (Campbell, Sefl, Barnes, Ahrens, Wasco & Zaragoza-Diesfeld, 1999). 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).

4.2 Previous Victimization

Researchers have found that some people become victimized again and again throughout their lives (Byrne et al., 1999; Messman & Long, 1996; Norris et al., 1997; Nishith et al., 2000). New victimization interferes with the person's ability to cope with past trauma. Furthermore, previous victimization affects how he will cope with the new trauma. In effect, the repeated victimizations interrupt the person's normal healing process. Norris et al. (1997) noted that crime challenges victims' 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 & Long, 1996; Norris et al., 1997; Nishith et al., 2000). Furthermore, previous victimization seems to affect the victim's reaction to new victimization, perhaps through low self-esteem, learned helplessness, poor relationship skills/choices, difficulty reading risky situations or poverty (Byrne et al., 1999; Messman & 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 victim's ability to rebuild herself and her life. Workers need to ask about previous traumas, both crime-related and otherwise. 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.

4.3 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). Researchers have noted that these problems can appear in victims of workplace violence (Rogers & Kelloway, 2000), stalking (Pimlott-Kubiak & Cortina, 2003), sexual assault (Byrne et al., 1999), childhood sexual abuse (Merrill, Thomsen, Sinclair, Gold & Milner, 2001), violent crime (Byrne et al., 1999), gang related violence (Ovaert, Cashel & Sewell, 2003) and family violence (Wolkenstein & 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 his trauma story while applying new skills to manage his feelings and thoughts (Bryant, Moulds, Guthrie, Dang & Nixon, 2003; Nishith et al., 2002).

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

In examining PTSD and anxiety, 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:

1) Fear/distress/worry
2) Physical symptoms (e.g., sweating, shaking, difficulty breathing, nausea, chest pain, dizziness, etc.)
3) Behaviour change (e.g., avoidance, rituals) and
4) Behaviours aimed at reducing distress (American Psychiatric Association, 1994).

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

1) fear
2) helplessness
3) intrusive and recurrent recollections
4) distressing dreams
5) reliving the event
6) intense distress
7) physiological reactivity
8) avoidance/suppression of thoughts/feelings, and
9) specific symptoms such as sleep problems, irritability, angry outbursts, poor concentration, hypervigilance and exaggerated startle response (American Psychiatric Association, 1994).

Dempsey (2002) found that criminal violence and negative coping predict PTSD, anxiety and depression to varying degrees. Daley, Hammen and Rao (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, Ruggiero, Acierno, Saunders, Resnick and Best (2003) found that almost 75% of adolescents who had PTSD also had either substance abuse problems or depression. 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 only certain types of trauma (Gilboa-Schechtman & Foa, 2001).

Figure 3: Depression

Depressive symptoms may include:

1) low mood
2) low appetite/weight loss
3) sleep problems
4) energy changes
5) self-blame/guilt,
6) worthlessness/ hopelessness,
7) difficulty concentrating and
8) thoughts of death
9) (American Psychiatric Association, 1994)

One question that is often raised when examining PTSD is, "Why does one person develop the disorder while others do not?" The following list of characteristics have been shown to be linked to increased chances of developing PTSD:

- Crime/trauma related factors (e.g., trauma severity related to sexual assault) (Brewin, Andrews & Valentine, 2000; Gilboa-Schechtman & Foa, 2001; Ozer, Best, Lipsey & Weiss, 2003);
- 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 following the crime (Ozer et al., 2003).

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

- Previous trauma (Brewin et al., 2000; Ozer et al., 2003);
- 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);
- Report of childhood abuse (Brewin et al., 2000);
- Education (Brewin et al., 2000);
- General childhood adversity (Brewin et al., 2000);
- Gender (Brewin et al., 2000);
- Age at trauma (Brewin et al., 2000); and,
- 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 his fear and anxiety (Bryant et al., 2003; Nishith et al., 2002). Workers untrained in these issues need to keep in mind the importance of consultation and making appropriate referrals to mental health professionals.

4.4 When Do I Need To Refer To Mental Health Professionals?

Mental health workers can provide support for more challenging clients. Although many victims can benefit from traditional services, some people 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, 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).

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. Of note, they also found that professional help was only effective if the help was prompt and ongoing (Norris et al., 1997).

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. This does not mean that you cannot work with the client but, rather, that you should consider if you need help:

1. When you suspect the person has depression, anxiety, post-traumatic stress disorder, continued dissociation or other mental health problems.
2. When suicide is a concern.
3. When intense emotions (anger/sadness/grief) are beyond your skills or resources.
4. When the person seems to be unmotivated and stuck.
5. When the person does not seem to get as much from group/self-help/other interventions.
6. When the person does not seem to be getting better even though they seem to be motivated and working hard.
7. When the person has a long, complicated history of victimization or abuse.
8. When 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 to problem-solve around 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, email or video-conferencing) to get guidance or receive 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. Of importance, workers should 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 the worker to ensure that she consults with others when outside her areas of expertise. Acting ethically and being respectful of your clients includes being aware of you own limits.

4.5 The Basics…

Reactions

- As people deal with being 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, supports and workers. Much care is needed to make sure that it is handled properly (Greenberg & 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/ judgement 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] Anger/hostility [1, 2, 3, 4, 7] Embarrassment [1] Anxiety [2, 5, 7] Depression [2, 4, 6] Grief [1, 2, 4] Guilt/shame [4, 5, 6] Difficulty controlling emotions [4] Apathy [5] Lower self-esteem [7]	Changes in relating to people [2, 6] Avoidance [5, 7] Alienation [5]	Intrusive memories [2] Lower self-efficacy [2] Vigilance [2] Flashbacks [5] Confusion/poor concentration [4, 5] Dissociation [4]	Nausea [1] Stomach problems [1] Muscle tension [1] Sleep problems [2]

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

Severity of Reaction

- All crime victims experience some distress upon being victimized (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).
- Sexual assault victims reported more severe reactions and took longer to heal than non-sexual assault victims (Gilboa-Schechtman & Foa, 2001).

- Workers need to be careful of groups that mix victims that 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 & Ruback, 1992).
- Workers should think about how to best match client needs to service level as a way to benefit clients (see Table 2).

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.
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 and display 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.

- Women may be at risk for more severe reactions as they are more likely than men to experience sexual assault or repeated victimizations (including sexual assault) (Pimlott-Kubiak & 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, Sefl, Barnes, Ahrens, Wasco & Zaragoza-Diesfeld, 1999).

Previous Victimization

- Researchers have found that previous victimization is a very strong predictor of further victimization (Byrne et al., 1999; Messman & 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 likely affects the victim's reaction to new victimization, perhaps through low self-esteem, learned helplessness, poor relationship skills/choices, difficulty reading risky situations or poverty (Byrne et al., 1999; Messman & 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 use this in our interventions.

Diagnoses Common to Victims

- 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/weight loss, sleep problems, energy changes, self-blame/guilt, worthlessness/ hopelessness, difficulty concentrating and thoughts of death (American Psychiatric Association, 1994).
- Anxiety symptoms can include: fear/distress/worry, physical symptoms (e.g., sweating, shaking, difficulty breathing, nausea, chest pain, dizziness, etc.), 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, accident, etc. (American Psychiatric Association, 1994).
- PTSD may include symptoms such as: fear, helplessness, intrusive and recurrent memories, nightmares, reliving the event, intense distress, being jumpy; avoidance/suppression of thoughts/feelings, and specific symptoms such as sleep problems, irritability, angry outbursts, poor concentration, hypervigilance and exaggerated startle response (American Psychiatric Association, 1994).
- Some risk factors to developing PTSD include: Crime/trauma related factors (Brewin et al., 2000; Gilboa-Schechtman & Foa, 2001; Ozer et al., 2003), 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 following the crime (Ozer et al., 2003).

When Do I Need to Refer to Mental Health Professionals?

- Worker should carefully consider when to refer to mental health professionals.
- Workers untrained in mental health issues should consult and make appropriate referrals to mental health professionals.
- Partnerships with healthcare, telehealth, consultation and visiting professionals are possible solutions for workers in isolated areas.

5.0 Coping with Being a Crime Victim

Workers should also be aware of how victims cope. Many different challenges face the victim: the shock of being a victim, dealing with the police/courts, 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 distress, 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 the person the opportunity to return to a "normal" life, victimization appears to have long-lasting effects (Gilboa-Schechtman & Foa, 2001; Norris et al., 1997). By understanding coping options for victims, workers can help victims to use this time to explore options and learn new, more effective coping strategies. Also, monitoring the use of coping strategies helps workers to assess client progress because research shows that victims use coping techniques less and less as they get better (Calhoun & Atkeson, 1991).

Before discussing specific coping strategies, a key distinction is necessary. 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 (e.g., blaming others, withdrawal, resignation, self-criticism, aggression, wishful thinking, alcohol/drug use). Dempsey (2002) found that using negative coping strategies could make the person feel worse. To muddy the waters, some researchers have noted that certain coping strategies, such as avoidance or dissociation, may be helpful to deal with the initial shock but become more damaging as time passes (Hagemann, 1992; Harvey & Bryant, 2002; Ullman, 1999). In fact, workers could think of negative coping strategies as the victim hanging off a cliff holding onto a weak branch: it may not seem safe but until given another option he trusts, he will not let go! Workers need to work with the client to help him replace negative coping strategies with more positive options; not just remove negative coping. Remember, crime victims are a diverse group and workers need to assess each person to understand his particular reaction. Table 3 lists the common coping strategies that victim of crime might experience. I will briefly discuss each in turn.

Table 3: Common Coping Strategies

Positive Coping Strategies	Negative Coping Strategies
Information seeking [5] Self-comparison/emphasize the positive aspects of surviving [1, 5, 12,20] Social comparison [4, 5, 9, 20] Activities to regain control [4,5] Activism [5] Time to heal [3, 5, 16, 18] Getting support [2, 4, 7, 10, 15, 16]	**Avoiding behaviour [2, 5, 13, 21, 22]** Denial and Self-deception [14, 19, 20, 21] Dissociation [6, 11, 16] Obsessing about the crime [4, 8]

[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] Hoeksema and Davis (1999)
[8] Holman and Silver (1998)
[9] Layne et al. (2001)
[10] Leymann and Lindell (1992)
[11] Martínez-Taboas and Bernal (2000)
[12] McFarland and Alvaro (2000)
[13] Mezy (1988)
[14] Mikulincer et al. (1993)
[15] Nolen-Hoeksema and Davis (1999)
[16] Norris et al. (1997)
[17] Ozer et al. (2003)
[18] Resick et al. (2002)
[19] Stillwell and Baumeister (1997)
[20] Thompson (2000)
[21] Ullman (1999)
[22] Wolkenstein and Sterman (1998)

5.1 Positive Coping Strategies

Information seeking

Often victims of crime simply want information (Hagemann, 1992). Useful information might include details about the justice system, program options, common reactions and so forth (Greenberg & Ruback, 1992). Gathering information can also be a key part to helping the victim to decide between different treatment options or even whether to seek help (Prochaska et al., 1992).

Cognitive reframe of victimization: Self-comparison/ 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 first embrace the term "victim" because it shows that the assault was not their fault. As they dealt with their experience, they switched to "survivor" because it reflects strength, recovery and being a fighter. This seemed 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 (Davis et al., 1998).

Put into lay terms, this point means: "That which does not kill you, makes you stronger." Successfully getting through a difficult situation seems to help victims see themselves as strong (Thompson, 2000) and the tougher the situation the greater the effect (McFarland & Alvaro, 2000). In fact, people will often see themselves as much weaker before the event, even if that is not true (McFarland & Alvaro, 2000). This may be in an effort to see benefit in an obviously difficult situation (Davis et al., 1998).

Cognitive reframe 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 use victims who are doing well as an inspiration to keep going (Greenberg & Ruback, 1992). This is a double-edged sword as they may also lose hope if they feel they can't make this same 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 and that they aren't worse off (Hagemann, 1992; Greenberg & Ruback, 1992; Thompson, 2000).

If other victims who are worse off aren't available, 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 & 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 in service of regaining control

Victims can also do things that make them feel more in control of their life. These empowerment activities might include victims of assault taking self-defence classes (Hagemann, 1992) or any crime victim laying charges and going to court (Greenberg & Ruback, 1992).

Activism

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

Use of social support

Crime victims often feel out of sorts (Casarez-Levison, 1992) and may seek others for support (Greenberg & Ruback, 1992; Leymann & Lindell, 1992; Norris et al., 1997). Research supports this activity, showing that people who get positive social support show better adjustment (Nolen-Hoeksema & Davis, 1999). 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 felt 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, Flannery & Mitchell, 2000).

Norris et al. (1997) noted that the victim benefits from talking to other people about her experience and feelings. Telling her story seems to help make sense of what happened and her emotions (Greenberg & Ruback, 1992). It may help her let go of troubling feelings or to get a "reality check" about her thoughts, actions and feelings (Greenberg & Ruback, 1992; Leymann & Lindell, 1992; Nolen-Hoeksema & Davis, 1999; Norris et al., 1997). Victims are often able to describe the type of support they want. Often we get caught up in providing the type of support we think victims need rather than asking them for guidance. The information in Table 4 will help workers think about support and match the victim's needs to which type of support to provide.

Table 4: Types of Support (developed from Leymann & 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 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., knowing 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). A possible explanation for this interesting finding is that people need to know that they can get support if they want it and that others are concerned. Thus, even knowing that their local community has a victim services office may help many victims cope---*without ever accessing services*! Needless to say, receiving actual support is also helpful to victims (Norris et al. 1997; Ozer et al., 2003).

Professional versus natural supports

Victims report their natural supports as being more useful than professionals (Leymann & Lindell, 1992). However, 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, Florian & Weller, 1993; Nolen-Hoeksema & Davis, 1999). In the worst case, the victim's natural supports may not believe him, causing even more distress (Leahy et al., 2003). In any case, the victim's social network can "burnout" leaving him feeling isolated and misunderstood.

Look back at Table 4 and imagine a friend trying to be emotionally supportive when the victim wants only information. This mismatch could result in his not going to that friend (or others!) again because of feeling frustrated and misunderstood. Of note, we all have our own way of coping with victimization. If we try to get others to adopt our style of coping, then they may feel that they have not been heard (Nelson et al., 2002). Professionals should be less likely to impose their views on the victim and work to meet him "where he lives". This is important because dealing with non-supportive people can add new layers of stress onto an already tough situation (Nolen-Hoeksema & Davis, 1999).

For these reasons, some victims may find it helpful to seek out professional support. In the ideal world, most professionals 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, victims do not need to be concerned about damaging the personal bond since the relationship is focused on dealing with the crime-related trauma.

5.2 Negative Coping Strategies

Avoidance: Active behavioural avoidance

Avoidance can show up as behavioural avoidance, such as staying in your apartment or taking time off work (Hagemann, 1992) or avoiding through self-medication, such as using alcohol, illegal drugs or overuse of prescription medication (Everly et al., 2000; Hagemann, 1992; Mezy, 1988; Wolkenstein & Sterman, 1998). Generally speaking, researchers agree that avoidance is a band-aid solution to the underlying trauma. However, initial avoidance of challenging situations may help the victim slowly build on small successes. In other words, initial avoidance may

allow the victim to take time to "lick his wounds" and gather resources to rebuild his life and deal with other challenges (e. g., the criminal justice system). As he receives treatment focused on confronting his fear, he is likely to feel better. However, those who self-medicate to avoid their pain, etc. are likely to experience even greater challenges, since using alcohol/drugs can often interfere with decision-making and coping (Kilpatrick et al., 2003).

Avoidance: 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) discussed the active blocking of memories and feelings to help cope with overwhelming emotions. Stillwell and Baumeister (1997) indicated 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 help seeking, they may also lessen initial distress (Hagemann, 1992). Ullman (1999) agreed and indicated that although avoidance strategies are usually linked to greater problems, they could also be adaptive in helping the victim get through the initial trauma.

Avoidance: Dissociation

Dissociation is a clinical term that means that there is a break in the person's normal way of thinking, his 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, the use of dissociation to cope seems to be more common in people with a history of frequent and severe traumatic experiences (Martínez-Taboas & Bernal, 2000). Workers need to remember that dissociation is a normal, adaptive way of dealing with trauma. Harvey and Bryant (2002) also indicated that naturally occurring dissociation might help the 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.

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

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 head 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 & 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, this focus may cause problems as the person works to move beyond the victimization experience because he is unable to focus on other aspects of his life.

5.3 Self-Efficacy

Researchers have identified self-efficacy as a characteristic that may make people less likely to develop a severe reaction to being victimized (Thompson, Kaslow, Short & Wyckoff, 2002). According to theory, people make choices based on their beliefs about their ability to control outcomes (Bandura, 1997). Self-efficacy is a merging of self-esteem with a belief that you can affect your environment. This is similar to confidence and opposite to learned-helplessness and feeling that everyone else controls your life and decisions. Basically, victims who believe they can successfully handle the crisis (self-efficacy) will have more positive thoughts, emotions and behaviours. Importantly, whether they are successful is less important than their confidence that they will be successful (Bandura, 1997). Over a lifetime, however, building up successes will increase self-efficacy and confidence. Contrast this to a lifetime of failure that decreases self-efficacy and challenges clients as they try to use new skills. 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 help seeking.

The role of self-efficacy in victimization may be best explained with an example. A victim of domestic violence may choose not to leave an abusive partner because of a belief that she cannot change her life or do well on her own (low self-efficacy). However, her experience of several "honeymoon" periods (times where her partner is on his best behaviour) gives her some confidence that she may be able to influence his behaviour, making things better. For example, she may have confidence (high self-efficacy) that she can keep their home stress-free by keeping the kids quiet and not bothering him after work. This confidence will increase the chance that she will stay in a potentially life threatening situation because she feels more in control of that situation.

In research on self-efficacy and battered women, Thompson et al. (2002) noted that helping women develop high levels of self-efficacy about living skills might increase the chance they would leave their relationship. As the woman becomes more confident about being able to build a social network and take care of herself and her children outside the relationship, she might begin to change her view of her current relationship. This challenges the "isolation" factor that one often sees in domestic violence relationships. Many treatments for victims include activities that require the victim to confront and successfully deal with difficult memories and emotions or learn and practice new skills (Nishith et al., 2002; Resick et al., 2002).

Self-efficacy may also explain coping choices. Bandura (1997) indicated that self-efficacy is key to changing behaviour because our perceptions of efficacy influence the use, intensity, and duration of coping behaviours. As stated above, self-efficacy develops out of previous successful experiences and is part of the victims learning history. Learning, experience and self-efficacy will influence what specific coping skills the victim will use. For example, if learning has shown her that dissociation is the best coping strategy, then it increases the chance that the victim will use it in new situations. This is especially true if other strategies have failed. On the

other hand, if the person has had success in receiving support from others, she is more likely to employ that strategy. Workers may recognize this in action when they see a client returning to old patterns, even when she knows that these old coping strategies do not work. To the victim this is returning to coping strategies that have worked for her in the past. New coping strategies have much "catch-up" to do to balance these poor choices. However, successful clinical programs often include elements of self-efficacy in helping victims, through focusing on challenges, successes and practicing new skills (Nishith et al., 2002; Resick et al., 2002).

5.4 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] Self-comparison/emphasize the positive aspects of surviving [1, 5, 12,20] Social comparison [4, 5, 9, 20] Activities to regain control [4,5] Activism [5] Time to heal [3, 5, 16, 18] Getting support [2, 4, 7, 10, 15, 16]	**Avoiding behaviour [2, 5, 13, 21, 22]** Denial and Self-deception [14, 19, 20, 21] Dissociation [6, 11, 16] Obsessing about the crime [4, 8]

[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] Hoeksema and Davis (1999)
[8] Holman and Silver (1998)
[9] Layne et al. (2001)
[10] Leymann and Lindell (1992)
[11] Martínez-Taboas and Bernal (2000)
[12] McFarland and Alvaro (2000)
[13] Mezy (1988)
[14] Mikulincer et al. (1993)
[15] Nolen-Hoeksema and Davis (1999)
[16] Norris et al. (1997)
[17] Ozer et al. (2003)
[18] Resick et al. (2002)
[19] Stillwell and Baumeister (1997)
[20] Thompson (2000)
[21] Ullman (1999)
[22] Wolkenstein and Sterman (1998)

Positive Coping: Social Support

- Social support is very important for many victims as they try to make sense of their victimization (Greenberg & Ruback, 1992; Leymann & Lindell, 1992; Norris et al., 1997).
- Victims find support from their family and friends more useful than support from professionals (Leymann & 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).
- Professional supports could be important when family and friends are overwhelmed (Mikulincer et al., 1993; Nolen-Hoeksema & 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 & Sterman, 1998).
- Although avoidance may help the victim deal with initial distress (Hagemann, 1992; Harvey & 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.

Self-Efficacy

- Self-efficacy is a merging of self-esteem with a belief that you can change your environment (Bandura, 1997). Basically, people who believe they can successfully handle the crisis (self-efficacy) will have more positive thoughts, emotions and behaviours.
- High self-efficacy may reduce the chances that the victim will have a negative reaction to trauma (Thompson, Kaslow, Short & Wyckoff, 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).

6.0 A Model for Client Change: The Stages of Change

Workers often face the problem of how to best 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 are 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).

Table 5: The Transtheoretical Model of Change (Prochaska et al., 1992)	
Precontemplation	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).
Contemplation	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.
Preparation	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.
Action	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 ask for help, seek help. It also ignores the work that follows treatment in staying healthy.
Maintenance	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.

6.1 How the Stages Work

Although very little work has been done linking these stages to crime victims, this model may be useful to workers in understanding those requesting services. One study looked at adult survivors of childhood sexual abuse receiving therapy (Koraleski & 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 therapy without being sure if they want to change. 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).

For these reasons, is it important that workers assess where the victim is on an issue, and not assume that just because she asked for help that she is ready for intensive treatment. In fact, this may overwhelm the victim and cause more distress. If we push her too much then it may result in the victim feeling attacked and increases the likelihood that she will quit and not receive the help she needs.

The biggest leap for clients happens as they move from the precontemplation stage to the following three stages (Rosen, 2000). Further, so-called precontemplators report more distress with treatment, less progress and are more likely to quit treatment early (Smith, Subich & Kalodner, 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 wisely use resources (both personal and funding).

6.2 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 to best help clients. Clients in the action stage are the clients for whom we train. They are 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 primarily 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. Recall, often precontemplators show up in our offices because others have sent them. Not only do these "consciousness-raising" activities help victims to learn about possible reactions, but these strategies also help victims link to the value of doing something about these negative symptoms or feelings (Prochaska et al., 1994).

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. Recall, 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. Progress and feeling better motivates clients.

These activities may help the victim take the big step of deciding she needs help or it may help her to address particularly painful problems. Further, these interventions can be useful for all clients. Imagine the 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 doesn't believe in him and that's why she keeps going to group. 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! Therefore, workers need to understand the victim's thinking and beliefs related to 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 client has reached her goals, she moves into the maintenance stage. In a sense this is what Casarez-Levison (1992) talked about when she described 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 practice those skills effectively. These relapse prevention strategies will help the client monitor himself and his world. For example, the victim 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 to not 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) noted 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 the client in his home life. The victim can also teach

his support system about these issues, helping his supports understand but also allow him to gain more control and self-efficacy by being able to educate others.

6.3 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, Subich & Kalodner, 1995).
- Most change happens when the 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). 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 healthy living skills, educating about early warning signs of backsliding, developing self-monitoring skills and other daily activities that are focused on gaining and maintaining control over his life. Allowing time for practicing 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.)

7.0 Assessment Issues: What Should I Ask About?

7.1 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 the victim a chance to talk about her 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 her story in her 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
- Rating of self-efficacy and resiliency
- Demographics
- Current coping strategies
- Use of alcohol/drugs
- Suicidality / Homicidality assessment
- Current mental status: Psychological disorders, coping, strengths, etc.
- Presence of dissociation
- Current support network
- Primary location in the Transtheoretical Model and identifying motivators
- Victim's perception of what she needs

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

As a victim shows increased distress and symptoms, he 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 might benefit from information sessions or written literature. Those clients having more severe reactions may need more intensive therapy or even inpatient treatment. A "one-size-fits-all-service" does not work efficiently. It is the matching of clients to a service within a continuum that will benefit the most clients.

8.0 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 can often be faced with people dealing with extreme distress, poor coping, mental health issues, little social support, repeated victimization and so forth. Basically, victims are a diverse group and will 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 practicing 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 with decision-making, learn new coping strategies, address supports, 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 the victim's natural support system. Workers are likely very familiar with working with the victims supports in ensuring a healthy environment for the victim.

8.1 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 as he copes 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 their normal way of gathering information. The following elements should be covered:

- History of childhood physical and sexual abuse (Messman & Long, 1996; Nishith et al., 2000; Pimlott-Kubiak & Cortina, 2003);
- History of previous PTSD (Brunet et al., 2001);
- Severity of previous PTSD episode(s) (Brunet et al., 2001)

- History of previous crime victimization or trauma (Byrne et al., 1999; Messman & Long, 1996; Norris et al., 1997; Nishith et al., 2000; Ozer et al., 2003);
- Psychiatric history, especially depression (Ozer et al., 2003);
- Family history of psychiatric problems (Ozer et al., 2003);
- Personality characteristics (Davis et al., 1998; Nolen-Hoeksema & Davis, 1999; Thompson et al., 2002);
- Coping history (Dempsey, 2002; Everly et al., 2000; Harvey & Bryant, 2002);
- Interpersonal relationship history (Kliewer, Murrelle, Mejia, Torres de G & Angold, 2001; Mikulincer et al., 1993; Nelson et al., 2002).

Victimization / disorganization

This stage focuses on the crime, and the first few hours or days following the crime (Casarez-Levison, 1992). Victims and their workers need to be aware of the following:

- Crime characteristics, especially severity, have a profound effect on trauma (Gilboa-Schechtman& Foa, 2001; Norris et al., 1997; Ozer et al., 2003);
- Victim characteristics such as gender, age, history, etc. can affect the victim's reaction (Brewin et al., 2000, Greenberg & Ruback, 1992; Pimlott-Kubiak & Cortina, 2003; Wilmsen-Thornhill & Thornhill, 1991; Weinrath, 2000);
- Caution regarding secondary victimization by the system (Campbell et al., 1999; Hagemann, 1992; Norris et al., 1997);
- 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 & Silver, 1998).
- There is a need for social support (emotional, informational, appraisal and instrumental);
- Gathering information aimed at helping the victim make decisions;
- Gathering information about resources and common reactions;
- Emotional reactions need to be experienced and processed;
- Assess the victim's coping strategies;
- Crisis intervention models may be useful in helping the victim overcome the initial challenges of surviving a crime (Calhoun & Atkeson, 1991).

Transition/ protection

This stage focuses on how the person begins to deal with the victimization and its meaning (Casarez-Levison, 1992). Professional workers are more likely to be actively involved with victims as they move through this stage.

- Natural and professional supports could be accessed (Casarez-Levison, 1992);
- May apply the Transtheoretical Model of Change to help identify what level of service is needed (Prochaska et al., 1992);
- Dissociation may indicate later difficulties (Ozer et al. 2003);

- There may be active blocking of memories (Thompson, 2000);
- Victims may avoid crime related reminders, either through drugs/alcohol or active avoidance (Everly et al., 2000; Hagemann, 1992; Mezy, 1988; Wolkenstein & Sterman, 1998);
- Victims may engage in safety-oriented behaviours (Hagemann, 1992);
- Victims may focus on meaning making (Gorman, 2001; Layne et al., 2001; Nolen-Hoeksema & Davis, 1999; Thompson, 2000);
- Social comparison is often used to understand victimization (Hagemann, 1992; Greenberg & Ruback, 1992; Thompson, 2000);
- Victims may engage in self-comparison activities, focused on pre/post victimization changes (McFarland & Alvaro, 2000);
- Active treatment may be initiated (Casarez-Levison, 1992);
- 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; Nishith et al., 2002);
- Self-efficacy may be important in treatment programs (Thompson et al., 2002);
- Emotionally engaged clients recover faster (Gilboa-Schechtman & Foa, 2001).

Reorganization/resolution

This stage focuses on the person becoming a stable functioning individual (Casarez-Levison, 1992). Workers and victims need to understand the following:

- 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 & 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 positive long-term outcome of victimization (Hagemann, 1992).

9.0 References

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