Working with Victims of Crime: The Basics

Information Sheet:
The Basics of Victim Reactions and Coping

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Reactions

- As people deal with being victimized, caregivers 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.

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] Muscles 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, Kaniasty and Thompson, (1997)

- 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.

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 below).

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 to isolated workers.

Table 3: Common Coping Strategies

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

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)

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 good strategies and bad strategies. Using bad strategies can make the victim feel worse (Dempsey, 2002).
- Table 3 lists the different coping strategies often used by victims.

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).

Other Information Sheets in this Series:

The Basics of Self-Care

The Basics of Victimization

The Basics about Deciding to Refer to Mental Health Professionals

The Basics about the Stages of Change

The Basics to Cover in an Initial Interview

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