Counseling Crime Victims
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Counseling Crime Victims

Practical Strategies for Mental Health Professionals

Laurence Miller, PhD

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Dedication

To those who give voice to the voiceless,

Names to the nameless,

And hope to the hopeless.

You know who you are,

And we remember what you do.
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Foreword

Victims of crime, particularly violent crime, face some unique challenges. They are thrust into a universe most never could have anticipated. Their formerly trusting perspective on human goodness surely will be threatened. Their assumptions of justice and the legal system can be contested in ways that defy how they can order their personal world.

If victims are fortunate enough to recover from physical injuries, many discover that the emotional impact cuts deeper than they would have suspected. That can further complicate their recovery as they second-guess whether they are “normal” after all.

Those who are committed to supporting victims in the aftermath of their emotional trauma discover that learning a whole new language and culture is a necessity for providing meaningful assistance.

Dr. Miller’s work is a practical primer on the recognized language and culture of crime victimization, particularly at the emotional and psychological level. While intended specifically for mental health professionals, this book is a valuable reference for all who serve victims in any direct capacity. He provides a sensible and functional breadth and depth of knowledge that exposes the extraordinary dimensions associated with victim response and intervention.

Those who have field experience will immediately recognize the functional nature of Dr. Miller’s labor while certainly discovering new insights for serving victims of all kinds.

Will Marling, MDiv, DMin, CCR
Interim Executive Director
The National Organization for Victim Assistance
January 2008
Preface

He didn’t just attack my body; he stole my soul.
—Sexual assault victim, 1997

More than an accidental injury, more than a serious illness, more than a natural disaster, the trauma of crime victimization goes beyond physical and psychological injury: It robs us of the very faith we have in the human world. Although eclipsed in recent headlines by terrorism, the common everyday violations of civilized behavior that our own citizens continue to perpetrate on one another are no less wrenching.

As more and more mental health professionals are becoming involved in the criminal justice system—as social service providers, victim advocates, court liaisons, expert witnesses, and clinical therapists—there has not been a commensurate improvement in the quality of teaching material to address this expanding and diverse field. Until now, students and practicing professionals have had to content themselves with either overly broad texts on criminology or trauma theory, or with narrow tracts on one or another subarea of victim services.

Counseling Crime Victims: Practical Strategies for Mental Health Professionals provides a unique approach to helping victims of crime. By distilling and combining the best insights and lessons from the fields of criminology, victimology, trauma psychology, law enforcement, and psychotherapy, this book presents an integrated model of intervention for students, trainees, and working mental health practitioners in the criminal justice arena. In this volume, I’ve tried to creatively integrate solid empirical research scholarship with practical, hit-the-ground-running recommendations that mental health professionals can begin using immediately in their daily work with victims. This includes direct advice to impart to victims and their families on how to stay alive during a crime in progress and on how to cope with police, clinicians, lawyers, judges, and social service agencies.
As in any solidly grounded but user-friendly volume, this book is part scholarly review, part practical clinical wisdom, and part personal journey. My own work with crime victims has converged from two directions. The first is the field of neuropsychology and traumatic brain injury and other traumatic disability syndromes, such as chronic pain and posttraumatic stress disorder. Many of these patients have been involved in motor vehicle or workplace accidents, but a fair number are injured in the course of a criminal assault. My work with physical and psychological trauma patients led to an interest in traumatic stress syndromes in law enforcement and emergency services personnel, and I soon found myself clinical director of the Palm Beach County Critical Incident Stress Management Team serving the county’s police officers, firefighters, and paramedics. This in turn led to my close and fruitful involvement with the West Palm Beach Police Department and other local and regional law enforcement agencies.

Around the same time, my practice in forensic psychology had been focused largely on civil cases involving workers’ compensation and personal injury but, as I became more involved with law enforcement and the criminal justice system, I began to see more and more criminal cases, both from the perspective of evaluating suspects for competency to stand trial and insanity defenses and evaluating victims for symptoms of stress and psychological disability. In addition to evaluations, many of these crime victim cases were referred to me for treatment. Thus, I’ve had the professional opportunity to experience the forensic psychological aspects of crime and crime victimization from the clinical psychology, law enforcement, and criminal justice perspectives.

For this book’s title, the term counseling is not chosen lightly and, as used throughout this book, has a number of important overlapping meanings and implications for treatment. To begin with, counseling encompasses all the phases and components of helping crime victims: psychological, legal, social service, philosophical, and spiritual; counseling is not just limited to weekly clinical sessions. An especially important dimension of counseling is its proactive nature: As I’ve emphasized elsewhere, the best form of crisis intervention is crisis prevention, and the best way to help a crime victim is to keep him or her from becoming one in the first place. Thus, this book places great emphasis on what might be called preventive mental health, by analogy to preventive medicine. Many of the strategies you’ll learn in the following pages can be used by your patients (and yourself) to keep them (and you) from being a victim, or in the case of a crime already committed, the strategies in this book can help mitigate the harm done.

But bad things do happen to some good, bad, or in-between people and counseling also incorporates a number of postcrime interventions for victims. Here again, the purview of counseling is broad and encompasses crisis
intervention literally within minutes of the traumatic victimization, to short-
term psychological stabilization, to later therapeutic processing, to long-term clinical follow-up and guidance through the civil or criminal justice system. To counsel your patient, then, is to directly aid him or her in the deepest, broadest way you can and help the patient secure the additional services that can assist further.

While we’re discussing semantics: The term victim is used purely descriptively in this book, to refer to someone who has had a criminal act perpetrated on him or her. It is not intended to be understood as any kind of a value judgment, as in the sometimes pejorative term victim mentality. Another semantic point refers to crime victims under clinical care who I here refer to as patients, simply because this is the terminology I was trained in and feel most comfortable with. Some clinicians are more comfortable with the term clients, in which case feel free to make that mental substitution while reading these pages. As an interesting linguistic aside, the term patient derives from the Latin, “one who appeals for help,” whereas the derivation of client is “one who depends.” Psychotherapists know that words and their meanings carry great weight in our interactions with patients. Thus, we must ensure that we communicate clearly and supportively to those we are trying to help.

The case examples chosen for this book are snippets of either actual cases (disguised for confidentiality) or composites of cases, and you will notice that many of them involve criminal victimizations that are not excessively gruesome or horrific. That’s because, in routine outpatient clinical mental health practice, you’re more likely to see larger numbers of noncatastrophic traumatic injuries and, consistent with the principle that everybody’s pain is real to them, it is essential to have the clinical and empathic skills to work productively with these crime victims, just as it is essential for the clinician who works in a hospital or other inpatient setting to have the skills to work with more severely injured patients. The principles in this book will apply to crime victims at all levels of injury and traumatization.

Although each chapter can be read on its own merits, this book is organized sequentially. Part 1 provides a solid clinical and empirical background on types of crime, victimization patterns, and common and unusual psychological reactions to crime victim trauma. I spend a good deal of time delineating various symptoms and syndromes because this richness of clinical presentation is what you’ll see in real-life practice and the first step to effective treatment is always proper diagnosis and case formulation.

The chapters in part 2 cover each stage of intervention involving a crime scenario, from preventing crimes from occurring or escalating, to immediate law enforcement and emergency mental health response to the crime scene itself, to short-term symptom management, to ongoing psychotherapy. This
includes strategies for working with direct victims of crime as well as family members of deceased crime victims, including children.

Part 3 applies the lessons learned in the previous chapters to addressing the unique needs of what might be called the “special victims” that you may encounter in your work: victims of sexual assault, domestic battery, workplace and school violence, and—in this new and strange age—victims of terrorism. A special chapter is devoted to the care and maintenance of mental health professionals—that’s you and me, folks—who do this kind of intense, gritty, demanding clinical work. Strategies are offered for beating burnout, staying sharp, and coping with the costs of caring. And if you work with crime victims, it’s inevitable that you’ll at some point become involved in the civil and/or criminal justice system; accordingly, the final chapter provides both you and your patients with a practical guide to forensic evaluations, courtroom testimony, and working with attorneys, victims rights groups, and social service agencies.

I’m counting on the fact that Counseling Crime Victims: Practical Strategies for Mental Health Professionals will not be the kind of book that readers flip through once and consign to bookshelf purgatory. I intend this volume to be the kind of dog-eared, Post-It-covered, underlined, yellow-highlighted, and margin-scribbled practical guide and reference book that working mental health clinicians consult again and again in their daily practices. This book will also be of use to attorneys, judges, law enforcement officers, social service providers, and other professionals who work with crime victims in a variety of settings. The book can also serve as a text for courses in clinical psychology, forensic psychology, criminology, and criminal justice.

Finally, only you will know if this book has accomplished its therapeutic mission, and the only way I’ll know is if you tell me. Therefore I invite readers to contact me with any comments, questions, critiques, or recommendations for future editions of this volume. Look, you don’t need me to teach you how to do psychotherapy; you’re already good clinicians, and the fact that you’re even holding this thick tome in your hands proves your dedication to enhancing and honing your professional skills. What this book will do is help you expand and apply those skills to the special needs of victims who have been assaulted in body, mind, and spirit so that you can guide these souls back into the human community they have been cast out of. So start reading, get to work, and let me know what you’ve accomplished.

Laurence Miller, PhD
October, 2007
A book like this has many points of origin and convergence, and its influences have been many and varied. The professionals I work with in the fields of psychology, law enforcement, and criminal justice continue to provide me with insights and experiences that I try to utilize in becoming a better practitioner and educator. The students in my courses and training seminars know that they serve me best when they challenge me to back up my ideas and present my practical recommendations in clear, convincing, and usable form. This book therefore represents an exercise in both learning and teaching.

Once again, I want to thank book agent James Schiavone for securing a most appropriate outlet for this work at Springer Publishing Company. Special thanks goes to International Journal of Emergency Mental Health editor Dr. Richard Levenson for his continued support of my published work in traumatology, victimology, criminology, and law enforcement psychology over the years. Rich also introduced me to Springer Publishing acquisitions editor Jennifer Perillo, who believed in this project and displayed Jobian patience while waiting for the manuscript to be completed (aw, c’mon, it wasn’t that late) and then, along with project manager Julia Rosen, she helped refine the manuscript’s essential message, with a collectively deft yet restrained redactive hand, into the practical guidebook you now hold.

I had always considered it a kind of cornball conceit for clinical authors to thank their patients (if you were so grateful, doc, did you cancel your bill?), and I’ve always viewed such acknowledgments skeptically—until it was my turn. My clinical patients and organizational consulting clients continue to reinforce the importance of seeing people—as both individuals and as groups—beyond the diagnostic labels and problem descriptions that often propel them into my office. So yes, they’re grateful to me for helping them, and I’m grateful to them for teaching me how to help others. It’s so corny, it’s actually true.
Other important lessons have been learned from the mental health clinicians, social service workers, victim advocates, support group members, and law enforcement officers I’ve worked with over the years. While I’d like to say that all of these professionals do their jobs out of selfless devotion to the welfare of others, let’s face it, for some it’s just a day’s work. But how they do that day’s work is what’s important, and I continue to be impressed by the way these individuals use their instincts, training, and common sense to do the kind of work that often necessitates making the impossible routine.

Last, but never least, my family once again earns my gratitude for enduring the prolonged absence of yet another self-imposed exile while completing this book. For better or worse, living with an author who often does his writing after coming home from his day job, they’ve learned to get used to brief glimpses of me when I pop my head out for air. But I hope they understand that I never stop appreciating their support for the work that I do.
PART I

Crime Victimization

Patterns, Reactions, and Clinical Syndromes
CHAPTER 1

Crime and Crime Victims

The Clinical and Social Context

Certain traumas do more than injure us; they violate our sense of security and stability, yank the existential ground right out from under our feet. More than most traumas—illness, technological accidents, natural disasters—violence deliberately and maliciously perpetrated by other people robs us of our sense that the world can ever be a safe place again. The suddenness, randomness, and fundamental unfairness of such attacks can overwhelm victims with helplessness and despair. As difficult as it may be to bear the traumas of injury and loss that occur in accidents and mishaps, far more wrenching are the wounds that occur at the deliberate hands of our fellow human beings, that result from the callous and malicious depredations of others. Assaults, rapes, robberies, and even petty but frightening harassments and threats can all nick, dent, and occasionally pierce the psychic shell of security we all envelop ourselves in to get through the day. Violent crimes shatter us in mind, body, and soul.

In some populations, as many as 40% to 70% of individuals have been exposed to crime-related traumas sufficient to meet diagnostic criteria for post-traumatic stress disorder (PTSD) and other syndromes (chapters 2, 3, 4), and many individuals have endured multiple exposures to such extreme stressors (Breslau & Davis, 1992; Breslau, Davis, Andreski, & Peterson, 1991; Breslau et al., 1998; Davis & Breslau, 1994; Norris, 1992; Resnick, Acierno, & Kilpatrick, 1997; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993; Scarpa et al., 2002). Except for rape, men appear to be assaulted under the same kinds of situations as women, but it may be more difficult for a man to report any kind of assault for fear of shame, ridicule, or disbelief (Saunders, Kilpatrick, Resnick, & Tidwell, 1989).
While almost any kind of violence can happen to anyone, certain types of criminal victimization appear to be relatively common in the clinical practice of trauma counselors.

**Criminal Assault**

Each year, more than 25 million Americans are victimized by some form of crime (Herman, 2002). The U.S. Department of Justice estimates that rapes, robberies, and assaults account for 2.2 million injuries and more than 700,000 hospital stays annually. Annual costs due to medical bills, mental health bills, and lost productivity are estimated to exceed 6.1 billion dollars. Indeed, even in this age of terrorism (chapter 14), for many Americans today, local violent crime is the overriding social and political issue. The bad guys seem to have gotten more brazen, while the rest of us cower helplessly, feeling victimized not just by the criminals but by the justice system that is supposed to protect us (Bidinotto, 1996; Kirwin, 1997).

“Give it up, bitch.” That was the first and last thing Janet heard before she hit the ground. Just seconds before, she’d been walking to her car in the parking lot of a shopping mall at dusk. Laden with packages, she didn’t see the tall figure in the green hooded sweatshirt until too late. The assailant pushed her to the ground and warned her not to look up or he’d shoot her dead. Rifling through her belongings, he apparently wasn’t satisfied with the yield and, out of frustration or sheer meanness, he put his foot on the prostrate woman’s cheek and proceeded to grind her face into the pavement for several seconds, telling her over and over again that she would be killed. Then, something must have startled him because, as quickly as he appeared, he abruptly fled. Mall security and the local police soon arrived, but the assailant was never apprehended.

“My whole life is ruined,” Janet later told her counselor. Several months after the attack, she could still not go to shopping malls, and seeing dark green clothing of any type produced terrifying flashbacks of the assault. Although she sustained only minor lacerations and abrasions on her cheek, she suffered bouts of excruciating facial pain. She was worked up neurologically for trigeminal neuralgia, but all the standard medical tests were negative. Sleep was almost impossible due to nightmares of being chased and attacked by “wild
animals.” Sometimes at night she could hear the phrase “Give it up, bitch” playing repeatedly in her head, which she described as being “like a stuck tape loop.” She got frequent headaches and night sweats and had lost more than 30 pounds. Her doctor prescribed tranquilizers and told her to “get some help.”

Criminal assault can be all the more psychologically destabilizing when it occurs on home ground, at home or work where we are supposed to feel safe.

His friends and family told him not to take his first Phys Ed teaching job in such a rough high school, but Mark had always prided himself on being a mediator and peacemaker. Besides, as a former high school and college football player and wrestling team member, he was hardly a wuss and could cut quite an imposing presence when he needed to show authority. So he didn’t think it would be that big a deal to break up a fight during a recess basketball game—until one of the combatants pulled a shank and stabbed him for his efforts. He recalls the emergency room doctors telling him his wound was potentially life-threatening and “I remember thinking, ‘how’s that different from really life-threatening?’ But at no time did I really think I was going to die. I figured I’d just take a few weeks off, get over this, and go back to work.”

And, being young, healthy, and enthusiastic, he recovered from his physical injuries. But even during his convalescence, he began noticing problems. Ball games on TV, which he used to love, now disturbed him, giving him “an itchy kind of nervousness” when he watched them. On his first day back at the high school, he was stunned to realize that he couldn’t bring himself to walk onto the basketball court. “It was like that force field on the starship Enterprise—I just couldn’t get past it. I’d get all dizzy and have to turn back.” Embarrassed and dismayed, he took a semester’s leave of absence and, as of last contact, hadn’t yet returned to teaching.

One of the realities of doing crime victim work is the realization that perpetrators and victims do not come in neat, separate, diametrically opposed packages. Some victims are targeted through no fault of their own, yet may lead questionable or marginal lifestyles that all too often put them in the wrong place at the wrong time.

“Hey, I’m no angel,” Manny allowed. “I like to party as much as the next guy. So maybe me and my crew were getting a little wild at the
bar, but, hey, you’re supposed to go there to have fun, right? All of a sudden, this bouncer is telling us to cool it or we’d have to leave. Hey, between the drinks and the girls, I already dropped a small fortune on that place, so I ain’t going nowhere, see? Okay, maybe I had an attitude and used a few choice words, but I sure didn’t start a fight. Next thing I know, I’m being bum-rushed out the door, so I kind of pushed back, you know? Then, there must be four, five guys on me, kicking and punching. At one point, I could hear my head crack and I thought I was gonna pass out. Then, I’m lying there on the sidewalk and my friends come out of the bar looking for me. I wanted to go back in, but they talked me out of it. So we went to some other place, but I don’t have a very good memory for the rest of that night.

“I figured that was that, but then for the next couple of days, I was feeling kind of tired and foggy and I was forgetting things, so I went to see a doctor who said it sounded like I had a concussion and told me to ‘take it easy’—yeah, like that’s gonna happen. Those fuzzy feelings passed after about a week or so, but then I noticed that going out with the guys at night wasn’t as much fun anymore. I’d sit in a bar or club and just kind of get bored or antsy, like I wanted to be somewhere else, so we’d go to a new place, but then I’d want to get out of there, too. I was starting to feel like a real drag and even my friends said I wasn’t much fun anymore.

“And, this is the weird part that I haven’t told too many people, but a few times I’d be sitting in a bar and I could swear I could see or feel a bunch of guys closing in on me like they were gonna attack me—but there was nobody there! That’s when I thought I was really starting to go nuts. And then, a couple of times a week, I’d be like half asleep, not a dream or anything, just like dozing off on the bus or while I was watching TV in bed or something, and I’d feel a crack on my head, like I got hit with a bat, and I’d bolt right up and feel my head, but there was nothing there. I went back to the doc who saw me for my concussion and he said to see somebody like you, so here I am.”

A number of diagnosable psychiatric syndromes may be seen following criminal assault. Depression, anxiety, PTSD, and substance abuse are common psychological disorders (chapters 2, 3, 4) found in victims of robbery, rape, and burglary (Falsetti & Resnick, 1995; Frank & Stewart, 1984; Hough, 1985), and a high proportion of panic attacks trace their onset to some traumatically stressful experience (Uhde et al., 1985). In a follow-up study, approximately 50% of crime-induced PTSD cases were found to persist in a chronic course after 3 months (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). Clinical
experience suggests that such traumatic effects may persist in some form for far longer—years, decades, or a lifetime.

A criminal act can affect those not directly assaulted or killed. When a family member has been murdered, surviving family members may be plagued by intrusive images of what they imagine the scene of their loved one’s death to have been, even if—perhaps especially if—they were not present at the time of the death (Falsetti & Resnick, 1995; Schlosser, 1997). Criminal assault survivors may be scapegoated and blamed for their attack by friends and family members seeking to distance themselves from the contagious taint of vulnerability that crime victims are all too often imbued with (chapters 2, 10).

Abduction and Torture

Perhaps the most extreme form of violence that one human being can perpetrate on another is abduction and torture. These acts typically take place in a military or political context, such as an act of terrorism, or as part of a civil crime such as a botched robbery, attempted extortion, sadistic sex crime, domestic dispute, or revenge. Treatment of captives can range from gracious to atrocious and may sometimes vary between these two extremes within the same event. The duration of captivity may range from minutes to years, but in most civilian crime settings, kidnappings or hostage crises where the victims survive are typically resolved within hours or days (Frederick, 1994; Mollica, 2004; Rosenberg, 1997; Miller, 2002c, 2005c, 2007h).

Stefan, a middle-aged businessman, was abducted from the underground parking garage of his office building by criminals who mistook him for an errant gang member who’d skipped with a large sum of their money. He was thrown into the back of a van and taken to a remote motel room where he was beaten and tortured for several days before finally being dumped unconscious onto a deserted street where he was found and taken to a local hospital. He claimed to have virtually no memory of the ordeal itself, aside from a few frightening dream-like images. In addition, his overall short-term memory and concentration were seriously impaired.

One of the differential diagnostic dilemmas in this case was figuring out how much of Stefan’s well-documented cognitive impairment was due to head trauma sustained in the beatings and how much to extreme psychological numbing associated with PTSD (chapter 2). Happily, this man was able to obtain a degree of justice in seeing his attackers prosecuted, which aided greatly in his integrating the trauma and getting on with his life (chapter 16). However, he will always
carry a certain edgy wariness about him, and he now tries never to go anywhere alone. Underground parking is out of the question.

It is hardly surprising that kidnapping, with or without actual physical violence, can produce severe posttraumatic stress reactions. Yet many captives manage to survive their ordeals relatively intact, some even emerging somewhat seasoned and ennobled by their experience. Several factors seem to be associated with better outcomes after hostage situations (Frederick, 1994; McMains & Mullins, 1996; Miller, 1998h, 2002c, in press-c; see also chapter 14):

- Age over 40
- A belief in one’s own inner strength of self
- Reflective thoughts of loved ones
- Faith in a higher power
- Continuing the hope that the captivity will end favorably
- Using one’s powers of reasoning and planning to figure out possible plans for escape or release
- Physical or mental exercise
- Appropriate expression of anger, where safe and feasible
- Ability to focus attention and become task-oriented

Psychological preparedness may promote a sense of control over the trauma (Hoge, Austin, & Pollack, 2007). In a study examining psychopathology in victims of torture, those who were political activists appeared to show more resilience. These individuals were thought to be relatively insulated psychologically by their commitment to a cause, training in stoicism, and prior knowledge about torture techniques (Basoglu et al., 1997). Other researchers have also found that prior training in emergency work appears to enhance resilience (Alvarez & Hunt, 2005; Hagh-Shenas, Goodarzi, Dehbozorgi, & Farashbandi, 2005; Miller, 1989b, 2005d, 2006m, 2007m; Regehr & Bober, 2004).

Crime in the Community

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association [APA], 2000) recognizes that posttraumatic stress reactions can occur in persons who observe terrible events happening to others, even if they are not directly, physically affected. This includes witnessing crimes of violence or threats of violence against others. Indeed, certain segments of the population may be exposed to traumatically stressful events on a fairly regular basis, for example, residents of crime-ridden and socioeconomically depressed inner-city neighborhoods.
Breslau and Davis (1992) and Breslau et al. (1991) studied over one thousand young adults from a large health maintenance organization in inner-city Detroit and found that many of these residents showed classic signs and symptoms of PTSD. Precipitating events included the standard traumatic events of sudden injuries, serious accidents, physical assaults, and rape. But also important was the traumatic effect of having one’s life threatened without actually being physically hurt, getting news of the death or injury of a close friend or relative, narrowly escaping injury in an assault or accident, or having one’s home destroyed in a fire. Overall, almost half of this sample of young, inner-city adults reported experiencing potentially traumatic events and about a quarter of them developed full-blown PTSD.

Many of the young adults with PTSD continued to experience symptoms for a year or longer. These chronic PTSD sufferers were more likely than those whose symptoms resolved sooner to show hyperreactivity to stimuli that symbolized the traumatic event, as well as interpersonal numbing (chapter 2). They were also more likely to report greater anxiety, depression, poor concentration, and medical complaints. Women were found to be more susceptible to PTSD than men, and subjects were more likely to experience traumatically stressful events if they were poorly educated, more outgoing, and impulsive; if they had a history of early conduct problems; or if they came from families with psychiatric and substance abuse histories. This makes sense: As noted above, people who are more impulsive and disturbed to begin with tend to take greater risks and more often find themselves in trouble-prone situations where they may be victimized and traumatized. Thus, in many cases, criminal activity may be as much related to the impulsivity and maladaptive lifestyle that leads to traumatic events in the first place as it is to the stress syndromes that result from those events; a similar relationship has been noted for impulsive antisociality, aggressive behavior, and traumatic brain injury (Miller, 1987, 1988, 1993e, 1994c, 1998d, 2001d, in press-d).

More recently, Breslau et al. (1998) surveyed over two thousand adults in the Detroit area, aged 18 to 45, to assess the lifetime history of traumatic events and PTSD. They found that almost 90% of the sample had been exposed to one or more traumatic events over their lifetime. The most prevalent type of trauma was the sudden, unexpected death of a close relative or friend. Men, non-White minorities, and economically poorer persons were more likely to be exposed to criminal assault, and assaultive violence carried the highest risk for PTSD, compared to any other kind of trauma. Another class of trauma with high PTSD rates was sudden unexplained death of a loved one. A little less than 10% of men exposed to traumatic events developed PTSD, and this rate was doubled for women. In most cases, PTSD persisted for more than 6 months, and the duration was generally longer for women.
More recent studies have demonstrated that young people as a group are at a disproportionately high risk of exposure to violence (see also chapter 13), with up to 80% of young adults reporting having been a victim of violence, and over 90% reporting being a witness to violence (Scarpa, 2001; Scarpa et al., 2002). Furthermore, this appears to produce a vicious cycle—the so-called cycle of violence—with those victimized showing more aggression themselves. Those most likely to turn their victimization into aggression appear to be characterized by high rates of victimization, avoidant and emotion-focused coping styles, and low perceived support from friends and others (Garbarino, 1997; Scarpa & Haden, 2006).

Real Crime Versus Fear of Crime

Now, some more bad news: Fear of crime may be hazardous to your health. Increasingly, social scientists are finding that the sheer overload of crime and disaster stories in the media, especially on local television newscasts, is giving the public a warped view of reality and contributing to a type of media-induced trauma known as *mean world syndrome* (Budiansky et al., 1996). Because most of the general public have little direct experience with crime, our beliefs about crime and the criminal justice system are largely based on what we see on TV and read in the newspapers, where sensational and violent crimes are often overrepresented. This may have the paradoxical effect of oversensitizing people to nonexistent or insignificant threats, while at the same time numbing the public’s understanding of the true impact of crime victimization when it does occur (Miller, 1995a, Miller & Dion, 2000; Miller, Agresti, & D’Eusanio, 1999).

Political scientist Robert Putnam of Harvard University has observed that the rise of television in the 1950s led to a “civic disengagement” of Americans around 1960. Television watching may breed pessimism and apathy. The mean world syndrome makes us paranoid about our neighbors and cynical about society and human nature in general (Budiansky et al., 1996). Just as importantly, if falsely exaggerating the extent of the crime problem contributes to a deterioration of mental health in individuals or groups, are news services liable for damages by engaging in what would amount to journalistic malpractice? Stay tuned.

RISK FACTORS FOR CRIME VICTIMIZATION

In general, women are more likely to be victims of sexual assault, often by people they know, such as husbands, ex-husbands, boyfriends, or relatives (chapter 10), while men are more likely to be physically assaulted by strangers. The risk of
sexual assault diminishes with age, while risk of physical assault increases with age earlier in life but then declines as men get older. Having been victimized in the past appears to be a risk factor for future victimization, probably because most people cannot easily escape the sociodemographic factors that put them at risk. Women are likely to develop PTSD at about the same rate following both physical and sexual assault, while the rate of PTSD for men is lower for physical assault but very high for sexual assault, which for men is a rarer and more humiliating event than physical assault (Kilpatrick & Acierno, 2003).

THE PSYCHOLOGY OF CRIME VICTIMIZATION

Russell and Beigel (1990) conceive of crime victimization as comprising several layers in relation to a person’s core self:

- *Property crime* like burglary generally hurts victims only at the outermost self-layer (i.e., their belongings), although the theft of certain meaning-laden family heirlooms can have a much greater emotional impact.
- *Armed robbery*, which involves personal contact with the criminal and threat to the physical self of the victim, invades a deeper psychological layer.
- *Assault and battery* penetrates still deeper, injuring the victim both physically and psychologically.
- *Rape* goes to the very core of the self; perverts the sense of safety and intimacy that sexual contact is supposed to have; and affects the victim’s basic beliefs, values, emotions, and sense of safety in the world.

Society’s response to crime also plays a role in how supported or abandoned victims feel (Russell & Beigel, 1990). For example, when a child comes home from school and tells his parents that the teacher was mean and made him sit in the corner, a common parental response is to inquire, “What did you do to make the teacher punish you?” From experiences such as this, many people grow up thinking that if something bad happens to them, they somehow deserved it. Also, taking the blame for something, even if you logically know it’s not your own fault, is often a more existentially reassuring stance than having to believe that something this terrible can just happen for no reason—because, if there’s nothing you did to contribute to it, then there’s nothing you can do that will prevent it from happening again, or something even worse happening, any time, anywhere (Miller, 1994b, 1996a, 1998e, 1998h, 1999d, 1999i, 2001d).
Society often regards victimization as contagious. In modern American culture, with its emphasis on fierce competition for limitless success and having it all, victims are often equated with losers. Most of us want to believe that crime victimization is something that happens to somebody else. The victim must have done something to bring it on him- or herself, otherwise, the reasoning goes, I'm just as vulnerable to the same bad fate, and who wants to believe that? We may thus be reluctant to associate with the victims for fear that their bad luck will rub off. All of these beliefs and reactions further contribute to the feelings of blame and shame that many crime victims experience (Miller, 1996a, 1998e, 1998h, 2001d, 2007l).

CRIME VICTIMIZATION: THE THERAPEUTIC MISSION

As therapists and counselors, we are not necessarily immune from these natural self-preservatory prejudices. What we can do is use our knowledge, training, informed intuition, and common sense to cultivate a comprehensive understanding of the wide variety of crime victim syndromes we will encounter in real-world practice in order to develop a flexible range of options for counseling, treatment, and direct services. As noted in the preface, counseling encompasses a wide range of services, from practical help to psychodynamic therapy. The principles of effective treatment are universal. This book will guide you in applying them to victims of crime.