CHAPTER

4 Trauma and Recovery of Victims

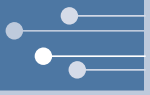
For victims to recover from a traumatic event, like criminal victimization, it is crucial that they are provided with the proper support. Often victims will require immediate crisis intervention during the initial impact stage, along with support throughout the criminal justice process. Victim service providers, therefore, have to be trained and ready to deal with a variety of responses when trying to assist victims. This is because people respond to traumatic events differently. Criminal victimization is arguably experienced more seriously than an accident or similar misfortune, as it is difficult to accept that the suffering and loss being experienced is the result of the deliberate actions of another person (UNODCCP, 1999). The initial reactions following victimization may include shock, fear, anger, disorientation, helplessness, disbelief, and guilt (Norris & Krysztof, 1994; Shapland & Hall, 2007). These psychological, emotional, and social responses are normal reactions to such a traumatic event. Victims' reactions depend on a number of factors: the context in which the victimization occurred, that is, the location of the incident, time of day it occurred, or the relationship to the offender; the victims' coping styles; and their resources (National Center for Victims of Crime [NCVC], 2012). The psychological responses can be either short-term or long-term (Hanson, Sawyer, Begle, & Hubel, 2010); however, if such crisis intervention is not received, the long-term effects can greatly affect the victims' recovery process. Trained victim service providers should inquire about the victims' welfare by asking if they feel safe, assuring victims that they are safe if that is true, and determining if they are in need of medical attention. It is essential for victim service providers to have an understanding of the impact of victimization and the variety of reactions victims may experience in order to assist in their recovery (Peterson & Walker, 2003). A victim's life may never be the same, but he or she can regain some form of control over his or her life and a sense of confidence (NCVC, 2012).

Physiological Impact of Victimization

The physiological reaction in response to a perceived harmful event, or when a person's physical survival is threatened, is known as the flight-fight-or-freeze response (Barlow, 2002; Bracha, 2004; Schmidt, Richey, Zvolensky, & Maner, 2008). This response is triggered to assist in determining whether fleeing from the situation, fighting, or freezing increases the chances of survival. The freeze response is an added dimension to the more common flight-or-fight response. Freeze responses may occur when an individual perceives there to be little immediate chance of escaping or winning a fight or when immobility increases the chance of surviving (Schmidt et al.,

CASE STUDY

Ridgeway Carjacking



It was a Wednesday evening, at 8:00PM; Denise and her son Steven had finished dinner with her parents and were preparing to leave to go home. Approaching her car, Denise noticed another car driving slowly past the house. Not paying much attention to the suspicious car, Denise and Steven proceeded to say goodbye to her father and started her car to leave. Suddenly, as she was leaving the driveway, the suspicious car she noticed earlier came speeding down the road and pulled in front of her, blocking her exit. Within seconds, a man had got out of the passenger side of the car with a gun, threatening Denise's father to stay back and not move. The man then approached Denise's window, pointing the gun at her head and demanding that she get out of the car. Denise opened the car door to get out, and as she was doing so, the man grabbed her arm and pulled her out the car. At this time, Steven was still in the passenger seat of the car. The man then got in the car and threatened Steven with the gun. With the gun pointed at his head and his hands in the air, Steven was unable to unlatch his safety belt to get out the car. The man, frustrated at the time it was taking Steven to get out the car, hit Steven on the head with the butt of the gun and unlatched the safety belt himself. While this was happening, Denise and her father could do nothing more than watch as all this was transpiring. Once unlatched, Steven exited the car. The driver of the suspicious car then pulled away, allowing the man in Denise's car to drive away with her car and all of her and Steven's personal belongings. They had just been carjacked.

Feeling shocked and scared, Denise, Steven, and Denise's father went inside and called the police. She also explained to her mother, who was inside at the time, what had just happened. The police and emergency personnel arrived. The emergency personnel examined Steven's head and were able to treat his injury at the scene. The police took their statements and questioned them for about an hour, asking for details about what happened, the offenders, and what type of car they were driving. The police officers left them with assurances that they would do everything they could to apprehend the carjackers. They also gave Denise information on victim assistance programs in the area where they could go to get further assistance following their victimization.

During the days and weeks that passed, Denise worked to file an insurance claim, cancel and replace her credit cards, and replace her driver's license and some of the essential items Steven needed for school, as those items were all in the car when they were carjacked. Neither of them followed up on the victim assistance programs. Denise, in particular, found it very hard to forget about the man and what had happened. In fact, she missed a week of work. She also found it difficult to sleep, experiencing night terrors and feeling very anxious. She began avoiding driving at night and also wanted someone to serve as a lookout every time she arrived or left her house. Denise also began to notify her family every time she was about to drive, with the idea that if she did not arrive somewhere in a certain amount of time, her family should worry and call the police. Three months after the carjacking, Denise was encouraged by a friend who had a similar experience to contact a victim assistance program to get help.

Questions:

1. Describe the type of stress Denise experienced and how it affected her following the victimization.
2. What type of coping strategies did Denise use following the victimization, and were they effective?
3. What would you recommend to help reduce the impact of the trauma she experienced?

2008). Simply knowing when to attack, flee, or freeze from situations that are perceived as harmful can be extremely complicated. Often the clarity of action to take is missing, for example, in situations such as domestic abuse or bullying (Peterson & Walker, 2003). Moreover, often stressors may be triggered by psychological events. For example, in response to victimization, frustrations in working with the criminal justice system, disruptions in life routines, and possible intrusions by the media may evoke both immediate and long-term reactions. Stress involves an intersection between psychological and physiological responses, the number of stressors faced today (i.e., pressure on the job, mortgage payments, children, health insurance) add to the varied reactions and coping styles of victims (Peterson & Walker, 2003; Regehr, LeBlanc, Barath, Balch, & Birze, 2013). What is good to know is that even with all the stressors facing each of us, better medication, nutrition, and counseling is available to help people live better lives.

Definitions of Stress and Trauma

To better understand the trauma and recovery of victims, it is important to have the key concepts of stress and trauma defined, as these terms are often used interchangeably in the literature (Boss, 2002). Puleo and McGlothlin (2014) explain that in Western culture, the word *stress* is generally used to describe emotional reactions ranging from feelings of mild irritation and frustration to being overwhelmed with fear. *Trauma* typically refers to the damage done to the biopsychosocial world of the individual as the result of a stressor or multiple stressors (Peterson, 2003). While the definitions may seem rather obvious, they have important distinctions within the context of providing assistance to victims.

Stress

From the biological perspective, **stress** is any demand made on a person that causes a reaction either biologically or psychologically. Stress causes changes in hormonal patterns, such as increased production of adrenalin and cortisol, which over time, may

Stress: any demand made on a person that causes a reaction either biologically or psychologically

deplete the body's energy resources, impair the immune system, and lead to illness (Dickerson & Kemeny, 2004; Puleo & McGlothlin, 2014). Everyone has some form of stress. Not all stress is bad stress, however. Some stress is needed for us to develop and even grow stronger. For example, working to solve a puzzle or problem is stressful but not overly so, and solving the puzzle or problem teaches individuals new ways to do things. Traveling is stressful but also exciting and enjoyable to many people. A good physical workout is stressful on the body but also enables us to feel good afterward and helps our bodies to grow stronger (Peterson & Walker, 2003).

Han Selye (1956) described two types of stress: (1) eustress, or positive stress, which is the result of changes in our environment that are perceived positively, and (2) distress, or negative stress, which is often harmful to the individual and caused by changes in the environment that are perceived negatively. Selye (1956) argued that distress tends to cause more biological damage to a person than eustress, which seemingly contributes to a person's well-being. Therefore, how a person perceives stress has an effect on how he or she will adapt (Selye, 1956; Regehr, Hill, & Glancy, 2000). Psychological distress often results in an inability to cope with the demands or pressures around us, and if severe enough, can potentially lead to psychological disorders such as anxiety, depression, and posttraumatic stress disorder (PTSD) (Regehr et al., 2000, 2013; Peterson & Walker, 2003).

Stress is therefore defined as "the demand, either physically or psychologically, that is outside the norm and that signals a disparity between what is optimal and what actually exists" (Peterson & Walker, 2003, p. 68). It is a part of life, and it is normal and impossible to avoid. There are events that may take place in a person's life that are stressful. Being injured in a skiing accident is stressful and so is losing your job; however, they are not the same types of stress and people respond differently in each situation, though some of the responses may overlap (Peterson & Walker, 2003). The degree of stress depends on the perceptions of, and meaning attributed to, the stressor event. Any form of stress has the potential to change some aspect of our life, but increased stress does not necessarily lead to a crisis. Often, stress is managed, and the individual or family can arrive at a new steady state (Jannoff-Bulman, 1992; Puleo & McGlothlin, 2014).

Trauma

Trauma: the result of severe distress and causes damage. Some stressors may be single incidents of relatively short duration, whereas others may occur over longer periods of time, resulting in prolonged exposure to the threatening stressor (Collins & Collins, 2005)

Stressors that involve trauma are powerful and overwhelming, and they threaten perceptions of safety and security (Puleo & McGlothlin, 2014). **Trauma** is therefore the result of severe distress and causes damage. Some stressors may be single incidents of relatively short duration, whereas others may occur over longer periods of time, resulting in prolonged exposure to the threatening stressor (Collins & Collins, 2005). According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) (American Psychiatric Association, 2013), a traumatic event involves the threatened or actual death or serious injury, or a threat to the well-being of oneself or to another person. Traumatic events may be human caused accidents or catastrophes, such as the Deepwater Horizon disaster which led to the largest oil spill in U.S. waters. An uncontrollable blowout caused an explosion on the oilrig that killed 11 crewmen and ignited a fireball visible from 40 miles away. The fire

was inextinguishable, leading to the rig sinking and the well gushing at the seabed, affecting much of ocean life in the area. The multiple terrorist attacks on September 11, 2001; the Boston Marathon Bombing on Patriots Day, April 15, 2013; and mass shootings such as those at Columbine High School in Littleton, Colorado, Sandy Hook Elementary School in Newtown, Connecticut, and the Pulse Club Shooting in Orlando, Florida, are all examples of acts of deliberate human actions, as are the numerous homicides and sexual assaults that occur in the United States each year. Other traumatic events include natural disasters, which include Hurricane Katrina that struck the Gulf Coast of the United States, leaving a wake of death and destruction in New Orleans, and the 2011 earthquake and tsunami that resulted in tens of thousands of deaths in Japan.

Traumatic events fracture and shatter the very basic assumptions people have about themselves and the world they live in (Jannoff-Bulman, 1992). This is because we develop theories about how the world works. For example, we trust that most people will act in benevolent ways. We expect that more good will happen to us than bad and never expect someone to steal our car, or be sexually assaulted, or kill someone we love. We know these things happen but assume that they will never happen to us. When they do, it is often not just a recovery from the specific acts of a violent crime that is needed but a recovery that involves a reorganization and understanding of ourselves and the world around us (Jannoff-Bulman, 1992; Peterson, 2003).

Responses to Trauma

Victimization causes many emotional responses that are normal: anger, rage, anxiety, fear, depression, and so forth (Kirchhoff, 2005). Most victims respond to traumatic events within a normal range of reactions to abnormal events, whereby the individual's baseline is not disrupted to the point that causes impairment or dysfunction. While others may become significantly distressed and impaired and develop psychological disorders such as acute stress disorder (ASD) and posttraumatic stress disorder (PTSD) (Andrews, Brewin, Rose, & Kirk, 2000). The risk of psychological disturbance tends to increase with the magnitude or intensity of the traumatic stressor and with the degree to which the event was human caused and intended to harm (Kirchhoff, 2005; Puleo & McGlothlin, 2014).

Reactions to traumatic events typically include physical, behavioral, cognitive, and emotional responses, which tend to occur in stages, but ultimately are temporary. The intensity of the reactions usually subsides over time. Physical responses involve the automatic nervous system that prepares the body to fight, flight, or freeze and may include heart palpitations, shortness of breath, nausea, muscle tension, headaches, and fatigue (Bracha, 2004). The physical problems created by stress will vary from person to person, but victimization can disrupt any of the body's systems and increase the risk of stress-related illness. Often victims want to regain control over their lives quickly and minimize an illness and not seek medical assistance. Victim service providers should support and encourage victims regarding concerns about health and assist them to obtain the appropriate medical care (Peterson, 2003). Behaviorally, victims may experience sleep and dietary changes, social withdrawal,

and purposeful avoidance of and attention to reminders of the traumatic event. Changes in relationships may also occur, along with an increased consumption of alcohol or mood-altering substances. These reactions may appear normal to victim service providers but present great distress for victims. Providing referrals for further counseling and evaluation may be necessary to help victims deal with these changes in behavior (Jannoff-Bulman, 1992; Peterson, 2003). The cognitive reactions victims may experience include rumination, preoccupation with the traumatic event, forgetfulness, and difficulty concentrating. A common indictor of cognitive problems for victim service providers to be aware of is the failure to follow a conversation by either diverting it or tuning out.

While many victims return to a healthy level of functioning, others experience consequences that greatly affect their ability to function. Mentioned above, the two most common psychological disorders victims experience are ASD and PTSD (Andrews et al., 2000). These two disorders are similar in their symptomology. According to the DSM-V, the diagnostic criteria for ASD and PTSD include hyperarousal (hypervigilance, difficulty concentrating, exaggerated startle responses, sleep disturbances), re-experiencing (flashbacks, nightmares, intrusive thoughts), and avoidance (attempting to avoid reminders of the traumatic event, inability to recall components of the event, detachment, disassociation, restricted effect), which cause distress and impair important areas of daily functioning. ASD is diagnosed if these symptoms appear within one month of the traumatic event. If these symptoms are experienced for more than one month, then PTSD may be diagnosed. If the symptoms persist for more than three months, PTSD is considered chronic (American Psychiatric Association, 2013).

PTSD can be debilitating and greatly impact a victim's ability to recover to a state of normal functioning. It is difficult to know how many crime victims experience PTSD. There are many events that can trigger PTSD symptoms. Entering the criminal justice system is one such example. Having to identify objects, people, or items related to the traumatic event, often many months later, can trigger a reaction. Anniversaries of the trauma or holidays near the date can have the same impact. Research has indicated that between 25% and 28% of crime victims experience PTSD (Resnick & Kilpatrick, 1994; Kilpatrick & Acierno, 2003). Victims of sexual assault, aggravated assault, or family violence and family members of homicide victims are more likely to develop PTSD (Black et al., 2011). High exposure to the criminal justice system almost doubles the victims' chances of suffering from PTSD. The negative psychological responses to victimization should be evaluated closely and taken seriously by victim service providers who should be distinctively aware of the symptoms of PTSD.

Resources

Resources: traits, characteristics, or abilities to meet the demands of a stressor event that can be available at the individual, family, or community level

Availability and access to resources following victimization can greatly reduce the effect of trauma. McCubbin and Patterson (1982) describe **resources** as traits, characteristics or abilities to meet the demands of a stressor event that can be available at the individual, family, or community level. There are two types of important resources: those that are available and used to settle the initial reactions to the stressor and those that are acquired, developed, or strengthened subsequent to a crisis situation (McCubbin & Patterson, 1982). Individual resources include education, health, employment, and

Table 4.1 DSM-V Diagnostic Criteria for Posttraumatic Stress Disorder

Posttraumatic Stress Disorder	
Diagnostic Criteria	**309.81(F43.10)**

Posttraumatic Stress Disorder

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic events(s) (e.g., first responders collecting human remains: police officers repeatedly exposed to details of child abuse).

   Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

   Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

   Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

   Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

(Continued)

Table 4.1 (Continued)

Posttraumatic Stress Disorder	
Diagnostic Criteria	**309.81(F43.10)**

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outburst (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Posttraumatic Stress Disorder

Diagnostic Criteria **309.81(F43.10)**

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for post-traumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent of recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individuals is experienced as unreal, dreamlike, distant, or distorted).

   Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Posttraumatic Stress Disorder for Children 6 Years and Younger

A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.

(APA, 2013)

individual psychological characteristics, whereas family resources include attributes of cohesion and adaptability and shared interests. Community resources include external supports such as social networks, victim assistance organizations, and law enforcement (UNODCCP, 1999). Assisting the victim to identify or reach out to resources provided by victim service providers can improve their daily functioning following a traumatic event.

Perception

The perception and interpretation of a traumatic event to an individual is important in understanding the different manifestations of reactions. How a victim reacts to such an event depends not only on the available resources but also the meaning he or she attaches to it. Puleo and McGlothlin (2014) write that meanings attributed to stressor events are subjective, and the factors that contribute to reactions include ambiguity (i.e., when facts cannot be obtained, or information is missing), denial, and the belief and value systems of the individual. Often following victimization, victims' perception of the world and the role people play in it changes. Questioning the senselessness and absurdity of a world in which human beings can be so cruel to one another greatly affects their reaction and ability to recover (Lerner, 1980; Hafer & Bégue, 2005). Victim support providers need to be nonjudgmental, supportive, and open in their responses to the interpretations and meanings ascribed to stressors by victims.

Coping

Coping: the thoughts and acts that people use to manage the internal and external demands posed by a stressful or traumatic event (Peterson, 2003)

Coping refers to the thoughts and acts that people use to manage the internal and external demands posed by a stressful or traumatic event (Peterson, 2003). It is a process where any behavioral or cognitive action is taken in an effort to manage stress. If the stressor is perceived as challenging or threatening (as opposed to irrelevant), the individual then determines what responses are possible and what their potential outcomes might be (Lazarus, 1993). There are two major categories of coping strategies: problem-focused strategies and emotion-focused strategies.

Problem-focused strategies are aimed at taking control of the stress. This involves changing or modifying aspects of the environment that are thought to be the causes of stress (Carroll, 2013). These efforts include seeking information or assistance, defining the problem, generating possible solutions and discussing their consequences, putting into place a plan of action, and finally acting upon it. Problem-focused strategies can be directed at the challenges and stress that come with being a victim of crime and are subsequent to the crime. These include dealing with media and the criminal justice system (Peterson, 2003; Puleo & McGlothlin, 2014). Emotion-focused coping strategies are used in the management of unchangeable stressors (DeGraff & Schaffer, 2008). Rather than changing the problem, as in problem-focused coping, this strategy involves the reappraisal process of the stressful situation, attempting to change the meaning of a stressor, or creating emotional distance from it and taking control over one's emotions (Carver, 2011). Using this strategy has assisted victims of crime dealing with emotions such as depression and anger (Folkman & Moskowitz, 2004). Depending on the type of stressor, a combination of these two types of strategies may be necessary in assisting a victim's recovery.

The effectiveness of any strategy is dependent on the context of the traumatic event. This means that any particular strategy the individual employs to cope with the trauma can be either adaptive or maladaptive (Kirby, Shakespeare-Finch, & Palk, 2011). Some responses that are typically viewed as maladaptive include increased drug and alcohol consumption (self-punishment) and avoidance, which are generally recognized as being detrimental to recovery. Adaptive coping incorporates efforts to seek support from

resources (family, community, etc.), to understand and express emotions in dealing with the incident, and to incorporate problem-solving activities to relieve the source of stress (Lazarus & Folkman, 1984). Better adjustment in the aftermath of trauma comes from the identification of coping abilities that encourage the engagement of resources and problem-solving skills.

Resilience

Resiliency is defined as a person's ability to maintain a balanced state in the face of challenges. In other words, it is the ability to "bounce back" after being traumatized, where the person is able to process and make sense of the disruption in his or her life, identify his or her resources, and successfully handle the crisis (Bonanno, 2004, 2005). Some victims are able to deal with their traumatic event without seeking professional help or ever coming to the attention of victim services (Gannon & Mihorean, 2005). People who are able to adjust to challenges are likely to have improved ability to cope. This may be emotional or behavioral adaptability or finding the positive elements in negative events (Bonanno, 2005; Tugade & Fredrickson 2007). Research on resilience has found that a variety of factors can operate to ensure resilience. These factors include social support, being socially competent, and being able to apply cognitive skills to solving problems. People who have social support and high-quality relationships show greater resiliency than those who have fewer social resources (Bonanno, 2005; Haskett, Nears, & Ward, 2006). While the decision regarding where to go for support lies with the victims, those who use their support systems are more likely to seek professional help, especially if they feel positively supported (Norris, Kaniasty, & Thompson, 1997). Social support and networks provide resources such as information that are important in dealing with adversity. People who are socially competent tend to have better communication skills, show empathy and caring, and demonstrate the ability to connect to others. Thus, social competency improves resiliency by helping the person meet any required needs (Haskett et al., 2006).

Finally, cognitive skills such as intelligence and problem-solving skills help the person to effectively examine and choose between different options in dealing with stress. Greater cognitive skills allow for people to generate more options and make them less likely to choose options with negative effects (Haskett et al., 2006; Gewirtz & Edleson, 2007).

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Reducing and Preventing Trauma

As previously mentioned, reactions to victimization differ all the time and from person to person, with numerous factors influencing these reactions: past experiences, general well-being, perception and meaning attributed to victimization, resources, and coping abilities. The longer the victim experiences any distress, the greater the potential for both psychological and physiological harm (Sorenson, 2002). It must be the goal of the victim service provider to assist in reducing stressors and to be alert to any signs of emotional or physical distress. The victim service provider must be prepared to deal with these reactions and those that may emerge in the aftermath of victimization and also to prepare

Victim's Assistance Programs

Connecting Mental Health & Education, Inc.

Connecting Mental Health & Education's aim is to provide therapy to all clients in need, especially those in grave danger. This includes therapy for those who suffer from depression, anxiety, or symptoms of post-traumatic stress resulting from abusive and criminal injustices. They focus on domestic violence (DV), child abuse, spousal abuse, and elder abuse. See http://www.connectingmentalhealth.com for more information.

the victim to deal with these (UNODCCP, 1999). There are a variety of ways to help reduce and prevent trauma. However, victim service providers need to be aware that some of the methods used to reduce stress and trauma are not equal in their effectiveness or efficiency and that service providers are not always able to assist victims. Therefore, victim service providers are encouraged to develop professional networks with police personnel, medical professionals, teachers, community leaders, religious leaders, and social service agencies who can offer further assistance to victims (UNODCCP, 1999).

Some of the options used to reduce and prevent trauma by victim service providers are trauma specific counseling, normalization, education (effects of trauma, legal advice, and injury), and developing the crisis story. Trauma-specific counseling is designed to treat only the crime that happened and any consequences or issues that arises in its aftermath. This does not mean that pre-existing issues should be ignored but rather that only once trauma-specific support has been initiated and addressed can other issues be dealt with (Jennings, 2004). Normalization involves reassuring victims that their traumatic reactions are common and to be expected (Young, 1993). To assist victims with normalization, introducing them to other stories of victims who have experienced similar crises often helps them to learn about the commonality of pain and emotional reactions. Education is a key component in reducing trauma and preventing trauma. Providing materials describing victims' reactions to trauma is valuable. This information may be ignored immediately following an event; however, in the following days, such information will be welcomed as the victims begin to reconstruct their lives. Education concerning physical injuries and where to get medical assistance is vital for victims. For example, such information aids the victim in better understanding the time and process needed for forensic examinations, along with how physical injuries may qualify them for victim compensation. Providing victims with information regarding legal implications is just as important. Information on what to expect from the criminal justice system informs victims of their options and steps that are taken to investigate, prosecute, and resolve the case (UNODCCP, 1999; Litz, Gary, Bryant, & Adler, 2002). Lastly, because recounting the crisis may be too painful and lead to re-experiencing negative emotional reactions, it is necessary for victims to develop a crisis story that aids them in avoiding these reactions. Victim service providers should let victims tell the stories they want to and not push for too much information. This can be done by assuring victims that what they are feeling is not uncommon and that they can stop telling their stories at any point and come back to them later (Young, 1993).

Most victim service providers recognize the fact that they may not be able to alleviate the continuing stresses of victims, but by providing the necessary reassurance, counseling, and education, they will help them to cope better with life's crises.

Stages of Recovery

Recovery is arguably the most important goal for victim service agencies. A recovered victim is one who has come to terms with having been victimized and who acknowledges what was lost. Having gone through this process, the victim is able to establish meaning from his or her experience and integrate what has been learnt to continue a functional life (Masters et al., 2017). Discussed already, working with someone who has experienced a traumatic event can be challenging, as everyone reacts differently. Despite the different reactions most victims go through, a three-phase process: impact stage, recoil stage, and the recovery achievement stage (Tyhurst, 1957; Office for Victims of Crime, 2001) have been commonly associated with victim recovery. Along with these phases, safety, remembrance and mourning, and self-care are identified as important concepts in the stages of recovery.

Victim Recovery

Based on research investigating individual patterns of responses to community disasters, J. S. Tyhurst (1957) identified three common phases victims go through following a traumatic event: impact stage, recoil stage, and recovery achievement stage. The impact stage follows the traumatic event and is when victims often experience shock, fear, anger, disbelief, numbness, and anxiety. Some victims are vulnerable to greater emotional reactions as they feel they are unable to protect themselves during this stage, while others may be able to react in a more rational manner. At this stage, victims' primary concerns are the basic needs of food, shelter, warmth, and safety. It is at this stage that victim service providers should ensure the victims' safety and identify the appropriate interventions by providing emotional and practical support, along with making referrals to mental health services should this be necessary to assist with long-term recovery (Herman, 1997; Masters et al., 2017). These first steps are essential to victim recovery.

In the recoil stage, the victims' reactions can vary from anger, rage, and helplessness to self-blame and even shame for what happened. Victims may ask in this stage "*why me?*" or "*why did I not do something different?*" These feelings can consume victims' every thought and greatly affect their ability to function normally in their daily lives. These feelings can cause negative physiological reactions, too. Headaches, stomachaches, insomnia, and lowered energy levels are common physical reactions to the preoccupation victims may have with the traumatic event (UNODCCP, 1999; Masters et al., 2017). Victims during this stage may require more extensive assistance from trained specialists such as psychiatrists' or psychologists. Victim service providers greatly assist victims in this stage by providing information about the victims' situation, accompanying victims' through the criminal justice system, and ensuring that they

receive the necessary services to help them function more effectively. The treatment option for victims may be either short term or long term. Short-term treatment options assist victims who have minor disorders, health issues, and problems managing stress. Long-term treatment usually addresses more severe reactions to trauma such as PTSD, anxiety disorder, and depression (Andrews, 1990; Yeager & Roberts, 2015). Reducing these symptoms of trauma assists victims with recounting and recalling the traumatic event without producing reactions characterizing the recoil stage (Herman, 1997).

The recovery achievement stage is marked by a renewed sense of empowerment and feelings that the traumatic event has become an integrated part of one's life story. Regardless of what may seem to be a setback, triggered by anniversaries and other reminders, victims in this stage are usually able to function with little or no disruption. Victims are also able to put into perspective that traumatic events, while not normal, do happen, and by overcoming the adverse consequences, they have a more positive self-perception and willingness to continue and possibly help others with similar distress (Herman, 1997; Van Camp, in press). Every victim deserves the opportunity to recover, and victim service providers are in the best position to assist victims in achieving this goal.

Safety

Safety: a sense of protection, well-being, and security. It is the feeling people experience when they are not in danger

Following criminal victimization, victims often state that their feelings of safety and security have been shattered. According to Bryant-Davis (2005), **safety** is a sense of protection, well-being, and security. It is the feeling people experience when they are not in danger. If people are safe, they feel comfortable expressing themselves, their thoughts, and their feelings. Feeling safe means that the person is less likely to be anxious and tense (Bryant-Davis, 2005). Because traumatic events produce distress and anxiety, along with endangering the victim physically and emotionally, it is not uncommon to feel afraid. Being afraid may affect victims' interactions with people, places, or social environments. Regaining feelings of safety and security is crucial for recovery. Moreover, being educated to identify possible unsafe situations or persons from safe ones is just as important. Victim service providers have to maximize every opportunity to increase victims' physical and emotional safety. This can be done by honestly assessing the victims' safety, and if they are not safe, determining the best steps they can take to increase their safety (Bryant-Davis, 2005). Depending on the traumatic experience, the victims may not feel that they are worthy of protection and safety. It is important for victim service providers to encourage and improve the victims' self-worth and make sure the interventions taken are focused on empowerment and increasing their perceptions of safety and security. It is impossible for victim service providers to prepare for all possible variations when working with victims, but they should have a strategy for safety planning and revisit it as circumstances change. Assisting with planning and assuring the safety of victims, family, and friends is important to ensuring that loved ones stay safe and recover effectively (UNCG, 2013).

Remembrance and Mourning

Most people remember events in their lives from childhood through to adulthood, and positive and negative events are usually a part of a person's memory. Traumatic events can remain embedded in victims' contemporary experiences. Victims need to be able

to confront their memories without becoming overwhelmed (Bryant-Davis, 2005). The more victims are able to do this, the more power the victims will gain over their memories and ability to function without disruption. As victims recall these memories, so too, they begin to confront them and work through the pain and begin to experience a decrease in anxiety (Foa & Rothbaum, 2001). Remembering transforms the victim's experience of the trauma. With the support and guidance of victim service providers and other resources, the memory goes from unbearable to bearable. Crisis intervention therapy and cognitive-behavioral therapy are individual therapies that have shown to best assist victims, effectively transform their memories, and improve a sense of self and empowerment (Foa & Rothbaum, 2001; Allen, 2005). Remembering and speaking the truth to traumatic experiences is a way for victims to move forward (Herman, 1997). Victim service providers can best assist victims in this regard by providing basic education on coping and self-care strategies and a list of available resources to where victims can get the type of assistance that deals with traumatic memories.

Mourning is experiencing grief for and recognizing the losses one has endured. It requires acceptance of the loss and capability to confront feelings of sadness (Bryant-Davis, 2005). Many victims try to avoid this process and deny the impact of the trauma, as it may reveal weakness or show that the event or perpetrator has power over them. It is healthy for people to mourn and allow themselves to feel a range of emotions. Like remembrance, it is important for people to confront these feeling, as by doing so, the person learns strategies to lessen emotional reactions (Young, 1991; Foa & Rothbaum, 2001). Victim service providers should develop strategies for surviving families and friends for coping through the mourning process and promoting growth to avoid remaining in despair. By learning and understanding that healthy expressions of sadness are necessary, people can move forward while still holding onto the lasting memories of loved ones.

Self-Care

Self-care is the opposite of self-harm. When a victim engages in self-care, they are expressing to others that they value their health and are finding ways to move on from the traumatic event. Self-care activities are important for every human being (Herman, 1997). Victim service providers should encourage the value of self-care particularly within the context of trauma recovery from a violation that affects a victim's sense of self-worth. Empowerment is key to self-care and should be done through the acknowledgment of barriers to resources, as well as strategies to assist in these barriers being overcome (Bryant-Davis, 2005). Self-care activities that should be encouraged include the following:

Self-care: is the opposite of self-harm. When victims engage in self-care they are expressing to others that they value their health and are finding ways to move on from the traumatic event. Self-care activities are important for every human being (Herman, 1997)

- Set aside time to rest and sleep (if the victim cannot sleep he or she should seek help)
- Eat regularly and healthy
- Maintain good and regular hygiene (cleaning one's body, teeth, hair, clothes, and living environment)
- Communicate with family and friends
- Try to be physically active

Victim's Assistance Programs

Mental Health America

Mental Health America is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans. Their work is driven by their commitment to promote mental health as a critical part of overall wellness, including prevention services for all; early identification and intervention for those at risk; and integrated care, services, and support for those who need it, with recovery as the goal. See http://www.mentalhealthamerica.net for more information.

- Take time to engage in enjoyable activities (reading, listening to music, watching a movie)
- Schedule regular preventative visits to support services and the doctor or go to the hospital when experiencing physical or emotional distress

SUMMARY

The initial reactions following victimization may include shock, anger, disbelief, and helplessness. These psychological, emotional, and social responses are normal reactions to such an event. It is crucial that victims are provided with the proper support, as these events can fracture and shatter the very basic assumptions people have about themselves and the world they live in. Crisis reactions tend to occur in stages but are often temporary with the intensity of the reactions usually subsiding over time. While many victims return to healthy levels of functioning, others may experience psychological disorders, such as ASD and PTSD. The stressor itself does not only determine how victims' and their families respond and adapt to traumatic events but also how the entire situation is perceived and the availability of resources. Recovery is arguably the most important goal for victim service agencies. A recovered victim is one who has come to terms with having been victimized and acknowledges what was lost. Having gone through this process, the victim is able to reestablish feelings of safety and security and find meaning from the experience that is integrated into his or her life story. Victim service providers need to be aware of the physical and emotional reactions of victims and be able to respond in proactive ways providing crisis intervention, strategies for recovery, and referrals to needed resources.

KEY WORDS

Coping 66
Resilience 67
Resources 62
Safety 70
Self-care 71
Stress 59
Trauma 60

INTERNET RESOURCES

The National Organization for Victim Assistance (http://www.trynova.org)

NOVA is a private, nonprofit, 501(c)(3) charitable organization. Its mission is to champion dignity and compassion for those harmed by crime and crisis. It is the oldest national victim assistance organization of its type in the United States and is the recognized leader in this noble cause. This website contains information about victim assistance.

The American Mental Health Counselors Association (http://www.amhca.org)

The American Mental Health Counselors Association (AMHCA) is the leading national organization for licensed clinical mental health counselors. AMHCA strives to be the go-to organization for licensed clinical mental health counselors for advocacy, education, leadership, and collaboration. Our organization provides the backbone of resources needed for clinical mental health counselors to thrive in today's world.

Coping with Trauma and Grief (https://victimsofcrime.org/help-for-crime-victims/coping-with-trauma-and-grief)

The National Center for Victims of Crime includes information on coping with trauma and grief. Furthermore, it provides links to resources for victims, including information about PTSD and resiliency.

The National Center for PTSD (http://www.ptsd.va.gov/)

The National Center for PTSD is dedicated to research and education on trauma and PTSD. The website publishes the latest research findings to help those exposed to trauma and those working with trauma victims.

CRITICAL THINKING QUESTIONS

1. List and discuss the three physiological reactions to traumatic events.
2. What are the ways people cope following a victimization? Discuss the two types of copying strategies used to help victims.
3. What are some steps victim services can take to reduce the impact of trauma?
4. Critically discuss the stages of recovery.
5. Why is self-care not only important for victims but also for victim service personnel, too?