

Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder

Specific Populations and Trauma Types Victims of crime and PTSD

This *Victims of crime and PTSD* information sheet addresses background issues and provides presentation, assessment and treatment recommendations for practitioners working with victims of crime. These recommendations are based on the systematic review of the international literature, and the expert opinion and advice presented in the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*. www.phoenixaustralia.org/resources/ptsd-guidelines/.

Background issues

There is debate in the literature about what constitutes a victim of crime, but the following United Nations[1] definition is widely accepted:

“... persons who, individually or collectively, have suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that are in violation of criminal laws operative within Member States, including those laws proscribing criminal abuse of power.”

Around 30 per cent of the Australian population report being a victim of crime (including robbery, burglary, attempted burglary, car theft, car vandalism, bicycle theft, sexual assault, theft from car, theft of personal property, assault and threats) in a given year. However, PTSD is not a potential outcome for all victims of crime. The diagnosis is applicable only in cases where the crime constituted a potentially traumatic event as defined by DSM-IV. In general terms these are crimes of an interpersonal and violent nature. A much lower, though still significant, proportion of the Australian population report being a victim of personal crimes, such as robbery, sexual assault and assault with force, which are more likely to be associated with subsequent PTSD. Males are more likely than females to be victims of all personal crimes, except sexual assault. For example, in 2009–2010, 3.4 per cent of males reported that they were a victim of physical assault (compared to 2.4% of females), while 0.4 per cent of females reported being a victim of sexual assault (compared to 0.1% of males).[2] However, because low incidence of reporting is suspected, the true figure of victimisation, particularly for sexual crimes, is unknown.

Presentation

The prevalence of PTSD in victims of crime is dependent upon the type of crime, the method of measurement and the definitions used. The lifetime PTSD prevalence rate for victims of crime is estimated to be about 25–28 per cent, with higher rates following interpersonal crimes such as rape (e.g., 45–60% following rape in both men and women).[3] It has been suggested that the fact that women report higher rates of PTSD than men may be largely explained by the fact that they are more likely to develop PTSD following assaultive violence; PTSD rates following other trauma types differ little.[4] In addition to being more common, PTSD is often more severe in victims of interpersonal or violent crime than survivors of other traumas.[5,6] It is thought that this may be partially explained by the intention by another human to cause harm, and the challenge this poses to the individual's long-held beliefs (e.g., that the world is generally a safe place and people are generally good).

In addition to more globally severe PTSD, victims of crime may present with more prominent disturbance in particular symptoms, such as exaggerated startle response, hypervigilance, emotional numbing, and re-experiencing symptoms such as nightmares and psychological distress when reminded of the event.[5,7,8] Individuals surviving assault are often avoidant of social situations, especially where there may be crowds or intoxicated people. Many may fear that the perpetrator will come back to hurt them again, even if the perpetrator has been incarcerated.

Note that the PTSD presentation commonly seen in this population is predominantly fear-based, in contrast to other presentations more reminiscent of depression (e.g., loss of interest in activities or concentration difficulties).[7] This has implications for treatment, as discussed below.

For some victims of crime, interactions with the criminal justice system serve as constant reminders of the trauma and can exacerbate distress. On the other hand, some may find comfort in the potential for the perpetrator to be held responsible for the crime, a resolution not often possible for survivors of other traumatic events.

Anecdotal reports suggest that PTSD in victims of crime is frequently erroneously diagnosed. It is likely that the diagnosis is sometimes given based upon the type of incident, rather than the actual presentation, with the symptoms cited to support the diagnosis frequently not PTSD criteria.

Assessment

The likelihood of legal proceedings raises issues of particular relevance to victims of crime during assessment, including:

- The practitioner should clarify with the person whether the interview is a forensic assessment or a therapeutic assessment; it is inadvisable for a single practitioner to attempt to fill both roles.
- A full assessment of the person's functioning and impairment before the crime in question and an assessment of current functioning need to be conducted.
- The full breadth of areas affected by the crime needs to be assessed – including reactions to both personal victimisation and property damage, subsequent family, vocational and social relationships, as well as the affective and psychological reaction of the victim.
- General interview-based questions need to initiate the assessment procedure rather than the use of specific questions or structured questionnaires, which may prime the person to answer in certain ways.
- Unless conducting a forensic assessment (or, if possible, even when conducting a forensic assessment), conclusions should be fed back to the person and explained appropriately so as to minimise later confusion should these results be called into court.
- It is essential that complete and full notes be taken during the assessment interviews and subsequent treatment sessions. Failure to do so may later prejudice the victim's rights should any court case ensue.

Treatment

Limited treatment research has been conducted with this population, although the available evidence supports the relevance and applicability of standard treatment guidelines for PTSD. The key recommendations, graded A through D depending upon the strength of the evidence, are:

Psychological interventions for adults

- For adults exposed to a potentially traumatic event, a one-session, structured, psychological intervention in the acute phase, such as psychological debriefing, should not be offered on a routine basis for the prevention of PTSD. **Grade B**
- For adults displaying symptoms consistent with acute stress disorder (ASD) or PTSD in the initial four weeks after a potentially traumatic event, individual trauma-focussed cognitive behavioural therapy, including exposure and/or cognitive therapy, should be considered if indicated by a thorough clinical assessment. **Grade C**
- Adults with PTSD should be offered trauma-focussed cognitive behavioural interventions or eye movement desensitisation and reprocessing. **Grade A**

Pharmacological interventions for adults

- For adults exposed to a potentially traumatic event, drug treatments should not be used for all those exposed as a preventive intervention. **Grade D**

- The routine use of pharmacotherapy to treat ASD or early PTSD (i.e., within four weeks of symptom onset) in adults is not recommended. **Grade C**
- Drug treatments for PTSD should not be preferentially used as a routine first treatment for adults, over trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing. **Grade B**
- Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor antidepressants should be considered the first choice. **Grade C**

An awareness of the legal system is important when treating victims of crime with PTSD. In Australia, the rights and laws pertaining to victims of crime are predominantly state-based rather than national, and hence vary between states. However, all the states have some mechanism whereby victims of crime can claim either compensation and/or access to mental health treatment for conditions related to their victimisation. Mental health practitioners need to have knowledge of these laws and services specific to where they practice.

Issues of particular relevance to victims of crime include:

- Due to the nature of criminal compensation some people may perceive a vested interest in maintaining symptomatology until all proceedings have been completed. Therapists are advised to address this issue with the person before initiating treatment. An open discussion of the pros and cons of maintaining symptomatology can often be useful.
- Additional time on arousal management strategies and cognitive techniques addressing erroneous beliefs about the likelihood of another assault may be required for some patients. (Obviously, realistic concerns about future assault need to be taken seriously – safety is a primary concern – but very often fears of another assault are grossly excessive).
- Prolonged imaginal exposure to the event, when managed by a well-trained therapist, has demonstrated efficacy with victims of crime and should be administered, sensitively, as a matter of course.
- It can be difficult for new therapists to avoid being compromised in their role as an agent of change and becoming, instead, an advocate. Therapeutic outcomes are best served through objective analysis of the presenting problems and the impartial application of evidence-based practice.
- In certain cases, it may be worth considering the recording of treatment sessions so that any accusations of tainted evidence arising during later litigation can be evaluated. Of course, the rationale for recording sessions should be carefully explained to the person and their consent obtained before recording begins.

Beyond these general considerations, an individual's needs will vary depending on the nature of the crime. For example, there is domain-specific knowledge related to rape victims that may be less relevant to victims of non-sexual assault and practitioners should acquaint themselves with these areas before providing treatment. Secondary consultation with a counsellor from a specialist sexual assault centre in your state would be recommended. The practitioner may also consider referring the person to a specialist sexual assault centre for advocacy or assistance with court proceedings if the practitioner is not going to offer this service themselves.

Working with children

Children and young people with PTSD resulting from being a victim of crime should be offered a course of trauma-focused cognitive behavioural therapy adapted appropriately to suit their age, circumstances and level of development.

Source and contributors

This information was taken from the Victims of Crime section (p.157-158) of the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* www.phoenixaustralia.org/resources/ptsd-guidelines/. The Victims of Crime section was developed by Phoenix Australia in collaboration with Associate Professor Grant Devilly, Clinical Psychologist, School of Applied Psychology, Griffith University.

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