

Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD



Phoenix
AUSTRALIA

Specific Populations and Trauma Types Victims of crime

This *Victims of crime* information sheet considers background issues and provides presentation, assessment, and treatment advice for practitioners working with victims of crime.

Background issues

The United Nations¹ defines a victim of crime in terms of:

"... 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."

The psychological effects of being a victim of crime may include distress, fear, and anger, and may be common in the aftermath of many forms of victimisation. However, the nature and level of these impacts will vary according to the type of event, and diagnoses of PTSD will only be appropriate in instances where the crime constitutes a traumatic event as defined by formal diagnostic systems. In the DSM-5, for example, a 'Criterion A' traumatic event is defined by death or threatened death, actual or threatened serious injury or sexual violation.² The ICD-11, in contrast, adopts a broader definition which references events defined by their exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.³ Thus, there are common types of crime (e.g., property crime) that are unlikely to be recognised as a traumatic event, and may instead be precursors to alternative diagnoses of adjustment disorder.⁴

PTSD is most likely to be an appropriate diagnosis following violent, interpersonal crimes which are characterised by injury, threat, and force (e.g., robbery and sexual or physical assault). Recent figures from the 2017-18 national Crime Victimization Survey in Australia suggests around five per cent of the population report being a victim of interpersonal crimes in a given year, with face-to-face threatened assault and physical assault being the most commonly reported crimes (2.6% and 2.4%, respectively).⁵ Males and females tend to report similar levels of physical assault (2.4% versus 2.5% for males and females, respectively) and robbery (0.3% versus 0.2%), while disclosures of sexual assault are more common among females (0.1% versus 0.5%).⁵ Exposure to family or domestic violence should also be recognised as a major form of criminal victimisation and human rights violation which is common among women (17% of women and 6% of men have experienced physical or sexual violence by a partner since the age of 15)⁶. However,

given the frequency of exposures and particular health-related burdens from family violence,⁷ this form of victimisation is considered in a separate information sheet.

Presentation

The conditional risk of developing PTSD for victims of crime involving physical or sexual violence worldwide is estimated to range from 1.8 to 19 per cent, with particularly high rates following rape and sexual assault.⁸ A recent systematic review identified a lifetime prevalence of 16.4 per cent for non-partner sexual violence in Australia and New Zealand.⁹ It has been suggested that higher rates of PTSD sometimes observed among women may be partly explained by the higher rates of exposure to sexual and assaultive violence.^{10,11} In addition to being more common, PTSD is often more severe among victims of interpersonal or violent crime, when compared to other traumas,^{12,13} while victims of violent crimes are estimated to account for one third of all lifetime PTSD episodes.⁸ This may be partially explained by the intention by another human to cause harm, and the challenge of this to the underlying beliefs of the victim that the world is generally safe and that people are generally good.

In addition to variability in global PTSD severity, victims of different types of crime may present with prominent symptoms such as exaggerated startle response, hypervigilance, emotional numbing, and re-experiencing.^{12,14,15} Individuals who survive assault may be particularly avoidant of social situations, especially where there may be crowds or intoxicated people. Many victims 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).¹⁴ This has implications for treatment, as discussed below.

For some victims of crime, interactions with the criminal justice system may serve as an ongoing reminder of the trauma and can exacerbate distress. On the other hand, some victims may find comfort in the potential for the perpetrator to be held responsible for the crime, which is a form of resolution that may be impossible for survivors of other traumatic events.

Anecdotal reports suggest that PTSD in victims of crime may be 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 not necessarily particular to PTSD.

Assessment

The likelihood of legal proceedings raises issues of particular relevance to victims of crime during assessment. For example:

- 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 should be assessed – including reactions to both personal victimisation and property damage, subsequent family, vocational, and social relationships, as well as affective and psychological reactions

- general interview-based questions should be used to initiate the assessment procedure, as opposed to structured questions or 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

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 across jurisdictions. However, all states have some mechanism whereby victims of crime can claim 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.

There are multiple issues which are of particular relevance to victims of crime. For example:

- due to the nature of compensation processes, some people may perceive a vested interest in maintaining symptomatology until 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 be useful.
- additional time spent on arousal management strategies and cognitive techniques addressing erroneous beliefs about the likelihood of another assault may be beneficial for some patients. (Obviously, realistic concerns about future assault must 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 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-focussed cognitive behavioural therapy adapted appropriately to suit their age, circumstances and level of development.

Source and contributors

The *Victims of crime* information sheet was developed by Phoenix Australia in collaboration with Associate Professor Grant Devilly, Clinical Psychologist, School of Applied Psychology, Griffith University, and updated in 2019 by Dr Sean Cowlshaw and Ms Isabella Freijah from Phoenix Australia.

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