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REFERENCES

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Alcoholics Anonymous. (1939). *Alcoholics anonymous*. Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Society of Addiction Medicine. (2021). *Definition of addiction*. https://www.asam.org/docs/default-source/quality-science/asam's-2019-definition-of-addiction-(1).pdf?sfvrsn=b8b64fc2_2

Brown, P. J., Stout, R. L., & Mueller, T. (1999). Substance use disorder and posttraumatic stress disorder comorbidity: Addiction and psychiatric treatment rates. *Psychology of Addictive Behaviors, 13*(2), 115–122. https://doi.org/10.1037//0893-164X.13.2.115

Burke, P. A. (2006). Enhancing hope and resilience through a spiritually sensitive focus in the treatment of trauma and addiction. *Journal of Chemical Dependency Treatment, 8*(2), 187–206. https://www.tandfonline.com/doi/abs/10.1300/J034v08n02_10

Burke, P. A., & Carruth, B. (2012). Addiction and psychological trauma: Implications for counseling strategies. In L. L. Levers (Ed.), *Trauma counseling: Theories and interventions* (pp. 214–230). Springer Publishing.

Burke, P. A., Carruth, B., & Prichard, D. (2006). Counselor self-care in work with traumatized, addicted people. *Journal of Chemical Dependency Treatment, 8*(2), 283–301. https://www.tandfonline.com/doi/abs/10.1300/J034v08n02_14

Canan, F., Karaca, S., Sogucak, S., Gecici, O., & Kuloglu, M. (2017). Eating disorders and food addiction in

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Coffey, S. F., Saladin, M. E., Drobes, D. J., Brady, K. T., Dansky, B. S., & Kilpatrick, D. G. (2002). Trauma and substance cue reactivity in individuals with comorbid posttraumatic stress disorder and cocaine or alcohol dependence. *Drug and Alcohol Dependence, 65*(2), 115–127. https://doi.org/10.1016/S0376-8716(01)00157-0

Colantuoni, C., Rada, P., McCarthy, J., Patten, C., Avena, N. M., Chadeayne, A., & Hoebel B. G. (2002). Excessive sugar intake causes endogenous opioid dependence. *Obesity Research, 20,* 478–488. https://doi.org/10.1038/oby.2002.66

Drewnowski, A., Krahn, D. D., Demitrack, M. A., Nairn, K., & Gosnell, B. A. (1995). Naloxone, an opiate blocker, reduces the consumption of sweet high-fat foods in obese and lean female binge eaters. *The American Journal of Clinical Nutrition, 61*(6), 1206–1212. https://doi.org/10.1093/ajcn/61.6.1206

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M.P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8. PMID: 9635069.

Garavan, H. (2010). Insula and drug cravings. *Brain Structure and Function, 214*(5–6), 593–601. https://doi.org/10.1007/s00429-010-0259-8

Grim, B. J., & Grim, M. E. (2019). Belief, behavior, and belonging: How faith is indispensable in preventing and recovering from substance abuse. *Journal of Religion and Health, 58*(5), 1713–1750. https://doi.org/10.1007/s10943-019-00876-w

Heilig, M., Epstein, D. H., Nader, M. A., & Shaham, Y. (2016). Time to connect: Bringing social context into addiction neuroscience. *Nature Reviews Neuroscience, 17*(9), 592–599. https://doi.org/10.1038/nrn.2016.67

Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror.* Basic Books.

Hudson, J. I., Hiripi, E., Pope, H. G. Jr., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 61,* 348–358. https://doi.org/10.1016/j.biopsych.2006.03.040

Hunter-Reel, D., McCrady, B., & Hildebrandt, T. (2009). Emphasizing interpersonal factors: An extension of the Witkiewitz and Marlatt relapse model. *Addiction, 104*(8), 1281–1290. https://doi.org/10.1111/j.1360-0443.2009.02611.x

Laudet, A. B., Morgen, K., & White, W. L. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug problems. *Alcoholism Treatment Quarterly, 24*(1–2), 33–73. https://doi.org/10.1300/J020v24n01_04

Leshner, A. I. (1997). Addiction is a brain disease, and it matters. *Science, 278*(5335), 45–47. https://doi.org/10.1126/science.278.5335.45">https://doi.org/10.1126/science.278.5335.45">https://doi.org/10.1126/science.278.5335.45

Madowitz, J., Matheson, B. E., & Liang, J. (2015). The relationship between eating disorders and sexual trauma. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 20*(3), 281–293. https://doi.org/10.1007/s40519-015-0195-y

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Potenza, M. N. (2014). Non-substance addictive behaviors in the context of DSM-5. *Addictive Behaviors, 39*(1), 1–2. https://doi.org/10.1016/j.addbeh.2013.09.004

SeekHealing. (2020, December 11). *Illness & health in an insane culture, Dr. Gabor Mate & Dr. Rachel Wurzman [Video].* YouTube. https://www.youtube.com/watch?v=smny3TTQmSc

Substance Abuse and Mental Health Services Administration. (2014a). *A treatment improvement protocol: Trauma-informed care in behavioral health services: TIP 57.*

Trauma-Informed Care in Behavioral Health Services. TIP 57. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4816.pdf

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American Society of Addiction Medicine. (2021). *Definition of addiction*. https://www.asam.org/docs/default-source/quality-science/asam's-2019-definition-of-addiction-(1).pdf?sfvrsn=b8b64fc2_2

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CHAPTER 14

Criminal Victimization

LAURENCE MILLER

CHAPTER OVERVIEW

This chapter focuses on the effects of criminal victimization and ways that counselors can respond effectively. This chapter discusses specific counseling responses, including symptom management, short-term mental health stabilization, and longer-term counseling and psychotherapeutic strategies. The counseling implications for working with crime victims are elaborated.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Define various types of criminal assault;
2. Understand the psychology of victims of crime;
3. Use specific responses for responding to victims of crime; and,
4. Develop strategies for immediate response, short-term intervention, and longer-term counseling for victims of crime.

INTRODUCTION

Although 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. These are discussed briefly in the following sections: Criminal Assault; Sexual Assault; Theft and Robbery; Crime in the Community; and Real Crime, Fear of Crime, and the "Mean World Syndrome."

Criminal Assault

Each year, more than 25 million Americans are victimized by some form of crime. Rapes,

Each year, more than 25 million Americans are victimized by some form of crime. Rapes, robberies, and assaults account for 2.2 million injuries and more than 700,000 hospital stays annually. Although the most violent crimes are committed by family members or close associates of the victim (Bidinotto, 1996; Herman, 2002; Kirwin, 1997; Miller, 2008a, in press-a), what most people fear most is an attack by a malevolent stranger.

Several diagnosable psychiatric syndromes may be seen following criminal assault (Miller, 2019). Depression, anxiety, posttraumatic stress disorder (PTSD), and substance abuse are common psychological disorders found in victims of robbery, rape, and burglary, and a high proportion of panic attacks trace their onset to some traumatically stressful experience. About half of crime-induced PTSD cases persist after 3 months, and clinical experience suggests that such traumatic effects may last for years or longer in some victims. Men appear to be subject to economic assaults, such as muggings and robberies, in similar situations as women, but are far less likely to be subject to sexual assault. However, it may be more difficult for a man to report any kind of assault for fear of shame, ridicule, or disbelief (Breslau et al., 1991, 1998; Davis & Breslau, 1994; Falsetti & Resnick, 1995; Frank & Stewart, 1984; Hough, 1985; Kilpatrick & Acierno, 2003; Norris, 1992; Resnick et al., 1997; Resnick et al., 1993; Rothbaum et al., 1992; Saunders et al., 1989; Uhde et al., 1985).

One of the realities of doing crime victim work is the realization that perpetrators and victims do not come in neat, separate, and diametrically opposed packages. Whereas some victims are targeted through no fault of their own, others may lead questionable or marginal lifestyles that all too often put them in the wrong place at the wrong time. Women who work in the adult entertainment industry may be targeted for sexual assault by males who feel "entitled" to have sex with women in these trades. People looking to buy or sell drugs may be assaulted and robbed. Members of a rival gang may be attacked for straying into alien territory or in retaliation for real or imagined aggression of their own. In such cases, counselors may have to negotiate the delicate task of suspending moral judgment in order to form a successful treatment relationship, while at the same time forthrightly addressing the risky behavior, in order to prevent (as much as possible) a repeat of the victimization (Miller, 2008a, in press-a).

Sexual Assault

Sexual assault affects one-fourth of women and up to 7% of men, and is associated with significantly increased risk of anxiety, depression, substance abuse, and PTSD (Elliott et al., 2004; Resick, 1993). As with all traumas, individual differences account for the severity of PTSD symptoms after sexual assault (Bowman, 1997, 1999). In particular, the PTSD symptoms of women who perceive negative events as uncontrollable tend to be more severe than those in women who believe that they have some ability to predict and control what happens to them (Kushner et al., 1993).

In addition to the general effects of crime victim trauma, some authorities have characterized the relationship between sexual violence and health as the *radiating impact of violent victimization* (Macy, 2007; Riger et al., 2002). In this conceptualization, violence influences women's physical and mental health, as well as radiating out to affect careers, friendships, families, and whole communities. Despite this impact, a surprisingly small number of sexual assault victims seek mental health services for problems related to their assault (George et al., 1992; Golding et al., 1989; Ullman, 2007).

Theft and Robbery

Although typically not lethal, to steal something from another person constitutes a fundamental violation of that person's dignity and bespeaks a callous disregard for their rights as a human being. This is why most of us react with that burning sting of outrage upon being tricked or strong armed out of what we believe is rightfully ours.

Theft refers to the illicit appropriation of resources that rightfully belong to someone else—in other words, someone taking what is not theirs. Although technically frowned upon in all cultures and considered a crime in societies with formal legal systems, it is nevertheless a cultural universal, occurring frequently in all human groups, as well as in many other animal

cultural universal, occurring frequently in all human groups, as well as in many other animal species (Kanazawa, 2008). More than 90% of theft and robbery crimes are committed by men, especially those who are poor, less intelligent, and have less education (Herrnstein & Murray, 1994; Kanazawa, 2004, 2008; Kanazawa & Still, 2000; Miller, 2012; Wilson & Herrnstein, 1985).

Burglaries involve breaking into a structure to steal something, usually without physical confrontation, although some burglaries can turn violent if the thief is surprised by the occupants. Some criminals also combine burglary with rape. Burglaries make up 11% of all thefts, and burglars are typically young males of low educational and socioeconomic status, with histories of substance abuse and other criminal behavior. The skill level of burglars can range from rank amateurs, such as bored teens breaking into a private residence, to professionals who hit wealthy homes or businesses that contain valuable items or large amounts of cash. Most private dwellings are burglarized during the day when occupants are likely to be out, whereas businesses typically are struck at night. Some burglars report experiencing a thrill or rush at breaking into a dwelling and stealing items. This thrill may take on a frankly sexual nature in the case of *fetish burglaries* in which intimate items are stolen, or in more violent cases, where rape accompanies the burglary. Some burglars may urinate, defecate, or masturbate in the burgled dwelling or otherwise vandalize the premises. Where the criminals force their way into the dwelling by overpowering the occupants, this is referred to as a *home invasion* (Bureau of Justice Statistics, 2003, 2006; Conklin, 1992; Miller, 2012; Palermo & Kocsis, 2005; Pitts, 2001).

Crime in the Community

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; [*DSM-5*; American Psychiatric Association, 2013) recognizes that posttraumatic stress reactions can occur in persons who observe terrible events happening to others, even if they are not directly affected, including 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. Precipitating events include sudden injuries, serious accidents, physical assaults, and rape, as well as having one's life threatened, receiving 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. Many of these individuals experience anxiety, depression, cognitive impairment, medical symptoms, and PTSD that persist for a year or longer. Furthermore, this appears to produce a vicious cycle—the so-called "cycle of violence"—with victims of aggression showing more aggression toward others (Breslau & Davis, 1992; Breslau et al., 1991, 1998; Garbarino, 1997; Scarpa, 2001; Scarpa & Haden, 2006; Scarpa et al., 2002).

Real Crime, Fear of Crime, and the "Mean World Syndrome"

Inasmuch as most members 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 or online, where sensational and violent crimes are often overrepresented, leading to a type of media-induced trauma known as *mean world syndrome* (Budiansky et al., 1996). 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, 1995, 2008a; Miller & Dion, 2000; Miller et al., 1999).

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 and vandalism, generally hurts victims at the outermost self-layer, that is, their belongings, although the theft or destruction 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

robbery, which involves personal contact with the criminal and threat to the physical self of the victim, invades a deeper psychological layer, while *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 security in the world.

Society's response to crime also plays a role in how supported or abandoned victims feel (Russell & Beigel, 1990). For example, society often regards victimization as contagious. In modern American culture, with its emphasis on fierce competition for limitless success and the perfect life, 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 themselves; otherwise, "I'm just as vulnerable too, and who wants to believe that?" We thus may be reluctant to empathize or associate with crime 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, 1998a, 1998b, 2001b, 2007b).

CRIME VICTIMIZATION: THERAPEUTIC AND COUNSELING GUIDELINES

Proper psychological intervention with crime victims ideally takes place at three levels and at three points in time: (a) at or close to the crime scene itself, involving crisis intervention and short-term psychological stabilization; (b) intermediate-level stress management and symptom-reduction strategies to allow the crime victim to achieve a sense of normalcy and control; and (c) more extensive counseling and therapy to help the victim work through the traumatic event and regain a sense of existential groundedness (Miller, 1998a, 1998b, 2008a, 2012, 2020).

On-Scene Crisis Intervention: Guidelines for First Responders

Ideally, effective mental health intervention for crime victims begins the moment the first responders arrive. For most crimes, this consists of police and paramedics, sometimes accompanied by a special mental health trauma clinician. In other cases, the first mental health contact occurs in the emergency department if the victim is taken to a hospital. Whoever the first responders are, they need to be aware that they are in a unique position to help the crime victim deal with the impact of their ordeal and to help restore a sense of safety and control to an otherwise frightening and overwhelming situation (Herman, 2002; Miller, 2000, 2008a, 2010).

First responders may face a confusing scenario when arriving at a crime scene. Traumatized victims may be in a state of shock and disorientation during the initial stage of the crisis reaction, feeling helpless, vulnerable, and frightened. Other victims may manifest fight–flight–or–freeze panic, and some actually may try to flee the crime scene. Some victims may be confrontational or combative with arriving police or paramedics, adding to the confusion as to who is the victim and who is the offender; this is most likely to occur in cases of barroom brawls, domestic disturbances, or neighbor disputes. In some instances, virtual physical and emotional paralysis may occur, rendering the victim unable to make rational decisions, speak coherently, or even move purposefully, much less seek medical attention or report the incident to the police. Balancing concern for victim welfare and the need to obtain detailed information thus becomes a delicate dance and requires some degree of interpersonal skill on the part of the interviewer (Box 14.1).

BOX 14.1

Tips From the Field

The following offers some practical recommendations for first responders who have to deal with crime victims on scene (Clark, 1988; Frederick, 1986; Miller, 1998a, 1998b, 2006a, 2010; Silbert, 1976).

Introduce Yourself

As soon as you arrive, identify yourself by name and full title to the victim and bystanders. Even with a uniform or ID tag, you may need to repeat the introduction several times; victims who are still in shock may respond to you as if you are the criminal, especially if you arrived quickly on the scene, unintentionally heightening their shock and disorientation. Children traumatized by adults may respond with fear to any new adult in their environment.

Apply Medical First Aid

It is typically the job of paramedics to render emergency medical care. But even as a mental health counselor, if you are one of the first responders on the scene, you may be the only one available to apply basic first aid until further medical help arrives. For whoever carries out this task, calmly explain to the crime victim what you are doing, especially when you are touching the victim or doing an otherwise intimate procedure, such as applying a breathing mask or removing clothing. If possible, encourage the victim to help you treat her, if she is capable and wants to, by having her hold a bandage or letting her undo her own clothing in order to afford some sense of control.

Respect the Victim's Wishes

When feasible, allow a requested family member or friend to remain with the victim during medical treatment or questioning by the police. If the present officer makes the victim uncomfortable, try to have a less threatening backup officer fill in for the questioning (e.g., a female officer for a rape victim; an ethnically or culturally familiar officer for a minority victim).

Validate the Victim's Reactions

Always try to normalize and validate the traumatic ordeal the victim has just been through and, as realistically as possible, reinforce their resilience and coping efforts thus far. In general, build on the victim's own resources to increase their feelings of self-efficacy and control, for example: "I can see this must have been a terrible experience for you; most people would be feeling pretty much like you are under these circumstances, but I'm glad to see you're handling it as well as you are."

Investigate Sensibly and Sensitively

Police typically prefer to interview crime victims as soon as possible to obtain fresh information that can be used to apprehend and prosecute the offender. Mental health clinicians who are on scene can assist and advise law enforcement personnel in these actions. This includes avoiding even unintentional accusatory or incriminatory statements, such as "What were you doing in that building so late at night?" A sympathetic, supportive, and nonjudgmental approach to law enforcement interviewing can do much to restore the crime victim's trust and confidence and thereby facilitate all aspects of the criminal investigation (Miller, 2006a, 2008a, 2010, 2012).

Present a Plan

Related to the issue of restoring control is having some kind of clear plan to provide further structure and order to an otherwise overwhelming situation. Such a plan needs to be backed up with concrete suggestions for action: "We're going to move to a safe area and have the medics take care of these cuts; then I'm going to ask you a couple of questions, if that's all right. After I'm done, I'm going to explain what happens next in the police process and legal area, and then I'll give you a card with some phone numbers of victim assistance agencies you can contact. I'm also going to give you my card, and you can contact me at any time for any reason. Do you understand? Do you have any questions?"

Employ Humor Judiciously

A tasteful witticism may add some perspective to the crisis situation and ease an otherwise tense situation, but traumatized people tend to become very literal and concrete under stress, and well-meaning humor may be mistaken for mocking or lack of serious concern. As with all such recommendations, use your professional judgment.

Utilize Interpersonal Calming and Coping Techniques

Never overlook the interpersonal power of a reassuring presence, both verbally and physically. Project a model of composure for the victim to emulate. Eye contact should be neither a detached glance nor a fixed glare, but more of a concerned, connected gaze. Stand close enough to the victim to provide proximal contact comfort, but do not crowd or intimidate by invading the victim's personal space. Use physical touch carefully. Sometimes, a brief pat on the shoulder or comforting grasp of the hand can be very reassuring, but it may frighten a victim who just has been physically assaulted. Take your cue from the victim.

SYMPTOM MANAGEMENT AND SHORT-TERM MENTAL HEALTH STABILIZATION

Clinicians often wonder, "When does crisis intervention end and 'real' psychotherapy begin?" However, the border between short- and long-term therapies is a fluid one, as is the line between so-called *superficial* and *deep* therapies. Much depends on the client. For example, helping a crime victim gain control of their bodily reactions—panic attacks, churning gut, and so forth—in the days and weeks following a physical beating, armed robbery, hostage scenario, or sexual assault may be an essential first step toward tackling the issues of safety and predictability that are raised in more extensive traditional trauma therapy. For other victims, even a cursory attempt to deal with symptoms must await the achievement of some degree of therapeutic confidence and stability. For many clients, this is a reciprocal cycle, with small increments in confidence permitting small steps toward symptom control, which in turn produce greater confidence and further attempts at mastery, and so on. In still other cases, clients may come to understand that although symptoms may be managed and controlled, they may never completely disappear but can be relegated to the background of consciousness, like "mental shrapnel" that only aches on occasion (Everstine & Everstine, 1993; Matsakis, 1994; Miller, 1994b, 1998b, 2012).

Modulating Arousal

The following sections present a flexible menu of cognitive behavioral symptom-control techniques that I have culled from diverse areas of practice and have used with diverse clinical populations, including crime victims, accident victims, law enforcement critical incident stress, military psychology, sports psychology, and others (Miller, 1989a, 1989b, 1994a, 2006a, 2006b, 2008a, 2008b, 2008c, 2012, 2013, 2020).

Progressive M'

For more than half a century, the technique of *progressive muscle relaxation* (Jacobson, 1938) has been the standard recipe of stress management and is by now so well-known that it only needs to be summarized here. The basic rationale is that much of what we experience as uncomfortably heightened arousal arises out of feedback from tensed muscles and other bodily signals of arousal. Essentially, then, the progressive relaxation exercise focuses on one muscle group or body area at a time and guides the subject through an alternate tense-and-relax sequence until all major muscle groups are in a state of relative physiological quiescence. This is typically combined with slow, steady, and diaphragmatic breathing (deep stomach breathing as opposed to shallow chest breathing) and one or more mental cuing or imagery techniques (see on the following texts) to further induce a state of

imagery techniques (see on the following texts) to further induce a state of psychophysiological calm.

The technique is first practiced in a peaceful, stress-free environment, such as in the therapist's office or in stress management class, guided by the clinician's or instructor's soothing words or by the use of a commercially prepared or custom-made relaxation tape, CD, computer, or cell phone app. Later, with continued practice in a variety of settings and conditions, traumatized crime victims should be able to self-induce the relaxed state on their own, in their natural environment, without external prompting, and without having to go through the whole tense-and-relax sequence each time. As an example, they can use it while sitting in traffic or at their desk at work.

Cued Relaxation

Once the progressive relaxation procedure has been practiced and mastered, many individuals are able to employ a kind of instant relaxation or *cued relaxation* technique. By voluntarily reducing muscular tension, taking a calming breath, and using a cue word, the subject learns to lower their physiological arousal immediately and thereby induce a more calm and focused mental state. The *cue word* or phrase may range from the spiritual ("God is with me," "Om") to the mundane ("Chill"; "Okay, I'm good") and is basically any word or phrase that the subject has learned to associate with the full relaxation response and that they can now say to themselves to signal their body to relax.

Similarly, a *cue image* is any mental scene the subject can invoke that has a calming effect, especially by virtue of having been paired with the initial relaxation response practice. Have your client pick the modality or technique that works best for them: the key is to invoke some cue that enables the client to quickly and voluntarily lower their arousal level to a degree that is appropriate for the situation they are in (Hays & Brown, 2004; Miller, 1994a, 2006b, 2008a, 2008b).

Centering

This is a technique derived from Eastern meditation (Asken, 1993) that involves combining diaphragmatic breathing with a *centering cue image*. The instruction to the client is as follows: "Begin by taking a slow, deep diaphragmatic breath. As you breathe out, slowly let your eyes close (or remain open if this is more comfortable for you) and focus your awareness on some internal or external point, such as your lower abdomen or an imaginary spot on the wall. Repeat this process until you feel yourself becoming calmer." As with all of these techniques, increased practice yields greater proficiency.

Mindfulness

For some people, "trying to relax" is a contradiction in terms; the more they try to force themselves to relax, the more tense they get. That is because, by definition, relaxation is something one has to learn to *let* happen, not something one can *make* happen, and some individuals are just too challenged by the process to allow this to take place comfortably. This may be especially common following a traumatic crime victimization, where "relaxation" may connote letting one's guard down and becoming more vulnerable. In *mindfulness* training (Kabat-Zinn, 1994, 2003; Marra, 2005), the individual makes no conscious effort to relax, but simply allows themselves to take in the sensations and images in the surrounding environment without trying to control them. Eventually, by taking the demand element out of the process, relaxation often will occur as a beneficial side effect. This technique may be especially useful with crime victims who already have enough to feel ashamed about without having to face the prospect of "failing" a relaxation assignment. Mindfulness training allows productive engagement with a therapeutic exercise that has as little demand as possible, thus allowing whatever small progress that occurs to be counted as a step in the right direction.

COUNSELING AND PSYCHOTHERAPY OF CRIME VICTIMS

Effective as they are, therapeutic symptom-reduction strategies have their limitations in

Effective as they are, therapeutic symptom-reduction strategies have their limitations in dealing with the full cognitive and emotional range of posttraumatic stress reactions and bringing about a reintegrative healing of the personality after crime victimization. For many victims, some form of constructive confrontation with the traumatic experience and its meaning has to take place in order to achieve a workable degree of mastery and resolution (Miller, 1998b, 2008b). It is important to bear in mind that symptom-oriented therapies and reintegrative therapies are not mutually exclusive; in fact, they reinforce each other, that is, sometimes, sufficient therapeutic trust, ego bolstering, and self-mastery through self-control must take place to lay the groundwork for more detailed direct exploration of the traumatic event itself (Brom et al., 1989; Everstine & Everstine, 1993; McCann & Pearlman, 1990).

Counseling and Therapeutic Strategies

As used here, a therapeutic *strategy* refers to an overall approach or game plan for addressing a problem or therapeutic issue, whereas a therapeutic *technique* is the actual nuts-and-bolts practical application of that strategy. For example, one strategy may be to help a victim feel more comfortable interacting with coworkers from the same ethnic group as their attacker by increased positive interaction with these peers. Specific techniques would include relaxation training, rehearsal and role-playing exercises, and gradually increasing time spent in interaction with these coworkers. In general, the effectiveness of any therapeutic strategy is determined by the timeliness, tone, style, and intent of the intervention. Effective psychological interventions with crime victims include the components discussed briefly in the succeeding subsections (Blau, 1994; Fullerton et al., 1992; Miller, 1994b, 1998a, 1998b, 2006a, 2008a, 2020; Wester & Lyubelsky, 2005).

Create a Sanctuary

One essential component of the therapeutic environment should be to provide a feeling of safety. The crime victim should be assured that what they say will be used only for the purposes of their healing and strengthening. Indeed, once the initial wariness passes, many victims report that they find the counselor's office a refuge- perhaps the only refuge—from the legal and family stresses that swirl around them in the wake of the crime, the only place where they can be "real." Of course, the limits of confidentiality must be carefully explained to the client, as she probably will be involved in legal proceedings, and the counselor's records may be subpoenaed or the counselor may be called to testify in court (Miller, 1996b, 2001a, 2007a, 2009).

Focus on Critical Areas of Conce

As with the general emphasis on quick mobilization of therapeutic gains and the client's sense of self-control, crime victim psychotherapy initially should be goal directed. It should remain focused on resolving specific adaptation and recovery issues related to the crisis at hand, which is a corollary of the next principle.

Specify Desired Ou'

In the beginning, the clinician needs to help the crime victim to operationalize these therapeutic objectives, in line with the emphasis on achieving practical goals. For example, the client might state, "I'd like to feel more at ease with my work and my family." The therapist can help him to objectify this general desire to more specific and achievable goals, such as, "I want to reduce the number of intrusive thoughts about the attack to a level where I can ride to work without panicking at each red light," or "I'd like to be able to step back for a few seconds to regain my composure before I blow up at my wife and kids again over nothing."

Of course, few distraught clients will come to the first session with a preset list of concrete goals; indeed, traumatized victims often are confused initially about what they hope to accomplish in therapy (e.g., "I just want the pain to go away," "I want to be able to sleep," "I want to think clearly again."). In the early phases, then, it is primarily the counselor's task to

help the victim sort out, focus, and operationalize their goals so that there can be a way of assessing if the therapy process is accomplishing them. Once again, without being overly rigid, specifying a doable goal and then setting to work on it can serve to focus and empower the out-of-control client.

Develop a General Plan

From the first session, after one or more workable goals have been elaborated, it is useful to develop an initial game plan that can be modified as counseling progresses. All the details need not be worked out at this point, and most likely, the plan will be revised as new information comes in. But the counselor needs to start somewhere, so developing a general road map allows the clinician to identify implementation and self-management strategies.

Identify Practical Initial Implementations

Clinicians should hit the ground running by beginning interventions as soon as possible. There is almost always some practical information, advice, or recommendation to provide, even in the first session. This induces confidence quickly, motivates further progress, and allows the counselor to get valuable feedback from initial treatment efforts thus far that can guide further interventions. Of course, counselors do not want to appear to be "pushing" these on the client; rather, interventions can be presented as a brief menu of options, allowing the client to make the choice when and if they are ready.

Review Assets and Encourage Self-Efficacy

Consistent with the overarching aim of posttraumatic psychotherapy as a strengthening, not weakening, process, it is as important to know what personal strengths and resources the client has as it is to understand their vulnerabilities. Counselors always strive to capitalize on strengths to overcome or work around weaknesses.

Counseling and Therapeutic Techniques

Adapted and expanded from psychological work with public safety personnel, the following therapeutic intervention techniques also have been found effective in working with traumatized crime victims (Blau, 1994; Miller, 1998b, 2000, 2006a, 2008a, 2008b, 2012, 2020; Miller & Dion, 2000; Silva, 1991). As always, clinicians should adapt and improvise these guidelines to the specific needs of their individual clients.

Attentive Listening

Attentive or active listening is a basic counseling skill. It includes good eye contact, appropriate body language, genuine interest, and interpersonal engagement, without inappropriate comment or unnecessary interruption.

Empathic Presence

Empathic presence is a therapeutic attitude that conveys availability, concern, and awareness of the disruptive emotions being experienced by the traumatized, distressed crime victim. Several victims have commented that they were put off by their counselor's detached, clinically aloof demeanor and did not feel as if the clinician really was prepared to engage them. Some of this may have to do with countertransference, vicarious traumatization, and emotional contagion issues on the part of the counselor (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). Alternatively, some victims may be unusually demanding of the counselor's time and devotion, necessitating the setting of realistic limits, while still retaining empathic engagement.

Reassurance

In acute stress situations, this should take the form of realistically reassuring the crime victim that routine matters will be taken care of, that deferred responsibilities will be handled by others, and that the victim has the support of their family, the mental health clinician, and the criminal justice system. It is also helpful to let the victim know, in a non-alarming manner, what they are likely to experience in the days, weeks, and months ahead. How much information is to be imparted, at what pace, and at what stages in the treatment process should be carefully calibrated to the client's recovering ego strength in order to avoid retraumatization. The key is to balance realism with reassurance.

Supportive Counseling

This includes active listening, restatement of content, clarification of feelings, and validation. It also may include such concrete services as community referral and networking with liaison agencies, if necessary.

Interpretive Counseling

This type of intervention should be used when the crime victim's emotional reaction is significantly greater or reaches into wider areas of the subject's life than the circumstances of the critical incident seem to warrant. In appropriate cases, this therapeutic technique can stimulate the victim to explore underlying emotional, personality, or psychodynamic issues that may be intensifying a naturally stressful traumatic event (Horowitz, 1986). In a few cases, this may lead to continuing, ongoing psychotherapy for broader life issues. The counselor should be careful, however, not to reflexively attribute any atypical reaction of the crime to their criminal victimization as stemming from "unresolved" childhood issues. These may well be important, but the counselor needs to be sure to understand what is happening in the here-and-now before delving into past psychodynamics.

Humor

Humor has its place in many forms of psychotherapy (Fry & Salameh, 1987) and may be especially useful in working with some traumatized crime victims (Fullerton et al., 1992; Henry, 2004; Miller, 1994b, 1998a, 1998b, 2006a, 2008a; Silva, 1991). In general, if the therapist and client can enjoy a laugh together, this may lead to the sharing of more intimate feelings. Humor serves to bring a sense of balance, perspective, and clarity to a world that seems to have been warped and polluted by malevolence and horror. "Show me a man who knows what's funny," Mark Twain said, "and I'll show you a man who knows what's not."

However, it is usually wise to maintain proper boundaries regarding destructive types of self-mockery or inappropriate projective hostility on the client's part. This may occur in the form of sleazy, cynical, or mean-spirited sniping, character assassination, or self-deprecation. Also, recalling the caveat for first responders mentioned previously, counselors should remember that many traumatized individuals tend to be quite concrete and suspicious at the outset of therapy, and certain well-intentioned kidding and cajoling may be perceived as insulting to the crime victim or dismissive of the seriousness of their plight; therefore,

insulting to the crime victim or dismissive of the seriousness of their plight; therefore, clinicians should always try to know the client and take their cues from them.

Utilizing Cognitive Defenses

In psychology, "defense mechanisms" are the mental stratagems the mind uses to protect itself from unpleasant thoughts, feelings, impulses, and memories. Although the normal use of such defenses enables the average person to avoid conflict and ambiguity and maintain some consistency to their personality and belief system, most mental health clinicians would agree that an overuse of defenses to wall off too much unpleasant thought and feeling can lead to a rigid and dysfunctional approach to coping with life. Accordingly, much of the work in traditional psychotherapy involves carefully helping clients to relinquish their pathological defenses so that they can learn to deal with internal conflicts more constructively. However, in the face of acutely traumatizing experiences, the last thing the affected person needs is to have their defenses stripped away.

For an acute psychological trauma, the proper use of psychological defenses can serve as an important "psychological splint" that enables the person to function in the immediate posttraumatic aftermath and eventually be able to productively resolve and integrate the traumatic experience when the luxury of therapeutic time can be afforded (Janik, 1991). In many cases, the clinician discovers that traumatized crime victims need little help in applying defense mechanisms on their own (Durham et al., 1985; Henry, 2004; Taylor et al., 1983). Examples of common defenses—all of which can have both constructive and maladaptive effects, depending on how they are used—include the following.

Denial: "I'm just going to put it out of my mind, focus on other things, and avoid situations or people who remind me of it."
Rationalization: "I had no choice; things happen for a reason; it could have been worse; other people have it worse; most people would react the same way I am."
Displacement/projection: "It was my boss's fault for sending me down to the basement so late at night; the police took forever to respond to the 911 call; the district attorney is going soft on this case because of politics."
Refocusing on positive attributes: "This was an isolated event—I'm usually a cautious, capable person. I'm a smart, strong person; I can get through this."
Refocusing on positive behaviors: "Okay, I'm going to follow safety procedures more carefully and talk to management about getting better security around here. I'm going to advocate for more safety training so nothing like this happens to anyone here again."

Where necessary, at least in the short term, counselors should know when to actively support and bolster psychological defenses that temporarily enable the traumatized crime victim to continue functioning (Janik, 1991). Only when defenses are used inappropriately and for too long, when they begin to hold the crime victim back from facing their fears and reentering the world, should we gently confront the now-maladaptive aspects in an atmosphere of safety and support (Miller, 1998b, 2008a).

Existential Issues, Therapeutic Integration, and Closure

In virtually every case of significant trauma, the victim struggles with shattered assumptions and fantasies about fairness, justice, security, and the meaning of life. Accordingly, it is a legitimate and, in some cases, essential part of the task of psychotherapy to help them come to terms with these existential issues. Some clients obsess over what they did or should have done to avoid or escape more serious harm or to help other people, and with these individuals, the therapeutic task becomes one of reorienting these clients to a more realistic state of self-acceptance. Many clients need to pass the anniversary date of the traumatic event, especially when their trauma was severe, before they can begin to bring the trauma response to closure. The process of simultaneously externalizing and integrating the crime trauma allows the last stages of recovery to take place. As the client approaches closure, the therapist can help them form a newly realistic and adaptive self-image, which becomes the

foundation for a healthy future (Calhoun & Tedeschi, 1999; Everstine & Everstine, 1993; Rudofossi, 2007; Tedeschi & Calhoun, 2004; Tedeschi & Kilmer, 2005).

Indeed, the diversity of human personality and the variation in severity and circumstances of the traumatic event virtually guarantee that different victims will have different reactions and that the therapeutic outcomes will vary as well. Thus, posttraumatic integration can be approached from one or more of three main perspectives (Everly, 1994, 1995).

Trauma Integrated Into the Client's Existing Worldview

The message here is that these things happen—people do hurt other people and undeserved injuries do befall innocent victims—but that the affected person is not helpless or hopeless, because there are certain precautions one can take to minimize the risk of this happening in the future. Such a message allows the person to feel reasonably safe again.

Trauma Understood as a Parallel Aspect of the Existing Worldview

The trauma is seen as an "exception to the rule." According to this interpretation, society sets up laws and structures to keep most of us safe most of the time, so this tragedy, while certainly awful, is really an isolated incident that, most likely, never will happen to the same person again. Of course, this must be realistically based; as noted earlier, in some communities, risk of repeated exposure to crime is a grim reality.

Trauma Illustrates the Need to Create a New and Modified '

The trauma can be used to demonstrate the invalidity of the client's existing perspective and the need to construct an alternative one in which the trauma more readily fits. For example, the assault shows the victim that the world is not entirely filled with good people, that justice does not always work out, and that sometimes the innocent suffer and the guilty go free. But the counselor can assist the client in fashioning a new way of looking at things that encourages both realism and cautious optimism; the client can learn to be clear headed, even skeptical, about human nature and motives but without allowing themselves to turn into a soul-shriveled cynic.

I have found that the subject's personality has a strong effect on which integrative strategy is most effective. For example, predominantly externalizing clients seem to adhere to the once-in-a-lifetime "lightning does not strike twice" type of explanation, putting their trust in fate or God or sheer statistical improbability. The "what can I personally do to keep this from happening again" type of reframe appeals more to clients who already possessed a degree of self-efficacy before the trauma and are therefore willing and able to try to solve problems by their own efforts once the therapist shows them the way. Still others may blend various perspectives together.

Finally, counselors must be mindful of victims who suffer from *enhanced integration* of the traumatic theme into their self-concept and life narrative (Berntsen & Rubin, 2007). For these individuals, the crime victimization becomes the exclusive focal point of their entire existence, and their lives become a ceaseless search for validation of their martyrdom. For such clients, the therapeutic emphasis must be on emotionally decoupling from the traumatic victimization and finding non-crime-related activities that encourage these individuals to resume a "civilian" life. In such circumstances, these clients may subtly or overtly shift gears to another alleged source of their woundedness and betrayal, such as family traumas, illness, or disability. Alternatively, they may quit treatment with one counselor and start over with another, more sympathetic counselor until that relationship sours as well, and so on.

Existential treatment strategies that focus on a quest for meaning may productively channel the worldview conflicts generated by the trauma event, such as helping the client to formulate an acceptable "survivor mission" (Shalev et al., 1993). Indeed, in the best cases, the rift and subsequent reintegration of the personality leads to an expanded self-concept and even a new level of psychological and spiritual growth (Bonanno, 2005; Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 1995, 2004; Tedeschi & Kilmer, 2005). Some trauma survivors are thus able to make positive personal or career changes out of a renewed sense of purpose and

thus able to make positive personal or career changes out of a renewed sense of purpose and value in their lives. Of course, not all crime victims are able to achieve this successful reintegration of the ordeal, and many may struggle with at least some vestige of emotional damage for a long time, perhaps for life (Everstine & Everstine, 1993; Matsakis, 1994; McCann & Pearlman, 1990). Therefore, the main caution about these transformational therapeutic conceptualizations is that they be presented as an opportunity, not an obligation.

The extraction of meaning from adversity is something that ultimately must come from the crime victim themselves and not be foisted on them by the therapist. Such forced existential conversions usually are motivated by a need to reinforce the therapist's own meaning system, or they may be part of what I call a therapeutic "Clarence-the-angel fantasy" (Miller, 1998b), wherein the enlightened counselor swoops down and, by virtue of the clinician's brilliantly insightful ministrations, rescues the client from their darkest hour and gives them a proverbial new lease on life.

Realistically, we can hardly expect all or even most of our traumatized clients miraculously to transcend their tragedy and thereby acquire a fresh, revitalized outlook on life—how many *counselors* would respond this well? But human beings do crave meaning (Yalom, 1980), and if a philosophical or religious orientation can nourish the client in their journey back to the land of the living, then our therapeutic role must sometimes stretch to include some measure of guidance in affairs of the spirit.

COUNSELING IMPLICATIONS

Psychotherapy with traumatized crime victims must span the range from concrete, supportive, and directive approaches to the most abstract, and even—in the broadest sense—spiritual modalities. Short-term crisis intervention can help restore a feeling of stability and control early in the trauma evolution process and possibly prevent the development of more disabling posttraumatic manifestations down the road.

Psychophysiological and cognitive-behavioral symptom-reduction strategies can help break the vicious cycle of escalating distress leading to greater helplessness, more severe distress, and so on. Psychologically integrative therapy and counseling approaches can help crime victims put their experiences into a narrative context to regain a sense of order and meaning in the world. Counselors who work with crime victims should master the fundamental skills of trauma therapy but be knowledgeable and flexible enough to allow each client's individual personality and recovery trajectory to guide intervention efforts.

CONCLUSION

Psychotherapeutic work with crime victim survivors often forces the clinician to confront the effects of human callousness and cruelty in all of its flesh-and-blood starkness. Working with these clients requires skill, dedication, patience, perseverance, flexibility, tolerance of partial solutions, and, sometimes, a strong stomach. But in many cases, the clinician will have the satisfaction of knowing that they have made a substantial impact, not just on the crime victim themselves, but on the larger radiating orbit of family, coworkers, and community.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Websites

Websites

National Center for Victims of Crime www.ncvc.org
National Organization for Victim Assistance www.trynova.org
Office for Victims of Crime http://www.ojp.usdoj.gov/ovc/help

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Asken, M. J. (1993). *PsycheResponse: Psychological skills for optimal performance by emergency responders*. Regents/Prentice Hall.

Berntsen, D., & Rubin, D. C. (2007). When a trauma becomes a key to identity: Enhanced integration of trauma memories predicts posttraumatic stress disorder symptoms. *Applied Cognitive Psychology, 21*. 417–431. https://doi.org/10.1002/acp.1290

Bidinotto, R. J. (1996). *Criminal justice? The legal system vs. individual responsibility*. Foundation for Economic Education.

Blau, T. H. (1994). *Psychological services for law enforcement*. Wiley.

Bonanno, G. A. (2005). Resilience in the face of potential trauma. *Current Directions in Psychological Science, 14*(3), 135–138. https://doi.org/10.1111/j.0963-7214.2005.00347.x

Bowman, M. L. (1997). *Individual differences in posttraumatic response: Problems with the stress-adversity connection*. Lawrence Erlbaum Associates.

Bowman, M. L. (1999). Individual differences in posttraumatic distress: Problems with the DSM-IV model. *Canadian Journal of Psychiatry, 44*(1), 21–33. https://doi.org/10.1177/070674379904400103

Breslau, N., & Davis, G. C. (1992). Posttraumatic stress disorder in an urban population of young adults: Risk factors for chronicity. *The American Journal of Psychiatry, 149*(5), 671–675. https://doi.org/10.1176/ajp.149.5.671

Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry, 48*(3), 216–222. https://doi.org/10.1001/archpsyc.1991.01810270028003

Breslau, N., Kessler, R. C., Chilcoat, H. D., Schultz, L. R., Davis, G. C. & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 Detroit Area Survey of Trauma. *Archives of General Psychiatry, 55*(7), 626–632. https://doi.org/10.1001/archpsyc.55.7.626

Brom, D., Kleber, R. J., & Defares, P. B. (1989). Brief psychotherapy for posttraumatic stress disorders. *Journal of Consulting and Clinical Psychology, 57*(5), 607–612. https://doi.org/10.1037/0022-006X.57.5.607

Budiansky, S., Gregory, S., Schmidt, K. F., & Bierk, R. (1996 March 4). Local TV: Mayhem central. *U.S. News and World Report*, 63–64.

Bureau of Justice Statistics. (2003). *Crime in the United States, 1976 2000*. National Institute of Justice.

Bureau of Justice Statistics. (2006). *Criminal victimization in the United States, 2005*. U.S. Department of Justice.

Calhoun, L. G., & Tedeschi, R. G. (1999). *Facilitating posttraumatic growth*. Lawrence Erlbaum Associates.

Clark, S. (1988). The violated victim: Prehospital psychological care for the crime victim. *Journal of Emergency Medical Services*. 48–51.

Conklin, J. E. (1992). *Criminology* (4th ed.). Macmillan.

Davis, G. C., & Breslau, N. (1994). Post-traumatic stress disorder in victims of civilian trauma and criminal violence. *The Psychiatric Clinics of North America, 17*(2), 289–299. https://doi.org/10.1016/S0193-953X(18)30115-1

Durham, T. W., McCammon, S. L., & Allison, E. J. Jr. (1985). The psychological impact of disaster on rescue personnel. *Annals of Emergency Medicine, 14*(7), 664–668. https://doi.org/10.1016/S0196-0644(85)80884-2

Elliott, D. M., Mok, D. S., & Briere, J. (2004). Adult sexual assault: Prevalence, symptomatology, and sex differences in the general population. *Journal of Traumatic Stress, 17*(3), 203–211. https://doi.org/10.1023/B:JOTS.0000029263.11104.23

Everly, G. S. (1994). Short-term psychotherapy of acute adult onset post-traumatic stress. *Stress Medicine, 10*(3), 191–196. https://doi.org/10.1002/smi.2460100309

Everly, G. S. (1995). The neurocognitive theory of post-traumatic stress: A strategic metatherapeutic approach. In G. S. Everly & J. M. Lating (Eds.), *Psychotraumatology: Key papers and core concepts in post-traumatic stress* (pp. 159–169). Plenum Press.

Everstine, D. S., & Everstine, L. (1993). *The trauma response: Treatment for emotional injury*. W. W. Norton & Company.

Falsetti, S. A., & Resnick, H. S. (1995). Helping the victims of violent crime. In J. R. Freedy & S. E. Hobfoll (Eds.), *Traumatic stress: From theory to practice* (pp. 263–285). Plenum Press.

Frank, E., & Stewart, B. D. (1984). Depressive symptoms in rape victims: A revisit. *Journal of Affective Disorders, 7*(1), 77–85. https://doi.org/10.1016/0165-0327(84)90067-3

Frederick, C. J. (1986). Post-traumatic stress responses to victims of violent crime: Information for law enforcement officials. In J. T. Reese & H. A. Goldstein (Eds.), *Psychological services for law enforcement* (pp. 341–350). U.S. Government Printing Office.

Fry, W. F., & Salameh, W. A. (Eds.). (1987). *Handbook of humor and psychotherapy*. Professional Resource Exchange.

Fullerton, C. S., McCarroll, J. E., Ursano, R. J., & Wright, K. M. (1992). Psychological responses of rescue workers: Firefighters and trauma. *The American Journal of Orthopsychiatry, 62*(3), 371–378. https://doi.org/10.1037/h0079363

Garbarino, J. (1997). *Raising children in a socially toxic environment*. Jossey-Bass.

George, L. K., Winfield, I., & Blazer, D. G. (1992). Sociocultural factors in sexual assault: Comparison of two representative samples of women. *Journal of Social Issues, 48*(1), 105–125. https://doi.org/10.1111/j.1540-4560.1992.tb01160.x

Golding, J. M., Siegel, J. M., Sorenson, S. B., Burnam, M. A., & Stein, J. A. (1989). Social support sources following sexual assault. *Journal of Community Psychology, 17*(1), 92–107. https://doi.org/10.1002/1520-6629(198901)17:1<92::AID-JCOP2290170110>3.0.CO;2-E

Hays, K. F., & Brown, C. H. (2004). *You're on! Consulting for peak performance*. American Psychological Association.

Henry, V. E. (2004). *Death work: Police, trauma, and the psychology of survival*. Oxford University Press.

Herman, S. (2002). Law enforcement and victim services: Rebuilding lives together. *The Police Chief, 69*(5), 34–37.

Herrnstein, R. J., & Murray, C. (1994). *The bell curve: Intelligence and class structure in American life*. Free Press.

Horowitz, M. J. (1986). *Stress response syndromes* (2nd ed.). Jason Aronson.

Hough, M. (1985). The impact of victimisation: Findings from the British Crime Survey. *Victimology, 10*(1–4), 498–511.

Jacobson, E. (1938). *Progressive relaxation*. University of Chicago Press.

Janik, J. (1991). What value are cognitive defenses in critical incident stress? In J. Reese, J. Horn, & C. Dunning (Eds.), *Critical incidents in policing* (pp. 149–158). U.S. Government Printing Office.

Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life*. Hyperion.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2), 144–156. https://doi.org/10.1093/clipsy.bpg016

Kanazawa, S. (2004). General intelligence as a domain-specific adaptation. *Psychological Review, 111*(2), 512–523. https://doi.org/10.1037/0033-295X.111.2.512

Kanazawa, S. (2008). Theft. In J. D. Duntley & T. K. Shackelford (Eds.), *Evolutionary forensic psychiatry: Darwinian foundations of crime and law* (pp. 160–175). Oxford University Press.

Kanazawa, S., & Still, M. C. (2000). Why men commit crimes (and why they desist). *Sociological Theory, 18*(3), 434–447. https://doi.org/10.1111/0735-2751.00110

Kilpatrick, D. G., & Acierno, R. (2003). Mental health needs of crime victims: Epidemiology and outcomes. *Journal of Traumatic Stress, 16*(2), 119–132. https://doi.org/10.1023/A:1022891005388

Kirwin, B. R. (1997). *The mad, the bad, and the innocent: The criminal mind on trial—tales of a forensic psychologist*. Little, Brown and Company.

Kushner, M. G., Riggs, D. S., Foa, E. B., & Miller, S. M. (1993). Perceived controllability and the development of posttraumatic stress disorder (PTSD) in crime victims. *Behavior Research and Therapy, 31*(1), 105–110. https://doi.org/10.1016/0005-7967(93)90048-Y

Macy, R. J. (2007). A coping theory framework toward preventing sexual revictimization. *Aggression and Violent Behavior, 12*(2), 177–192. https://doi.org/10.1016/j.avb.2006.09.002

Marra, T. (2005). *Dialectical behavior therapy in private practice: A practical and comprehensive guide*. New Harbinger.

Matsakis, A. (1994). *Post-traumatic stress disorder: A complete treatment guide*. New Harbinger.

McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. Brunner/Mazel.

Miller, L. (in press-a). *Criminal psychology: Concepts and applications*. AB Longman/Pearson.

Miller, L. (in press-a). *Criminal psychology: Concepts and applications*. AB Longman/Pearson.

Miller, L. (in press-b). Psychotherapy with military personnel: Lessons learned, challenges ahead. *International Journal of Emergency Mental Health*.

Miller, L. (1989a). To beat stress, don't relax: Get tough! *Psychology Today, 23*(12), 62–63.

Miller, L. (1994a). Biofeedback and behavioral medicine: Treating the symptom, the syndrome, or the person? *Psychotherapy, 31*(1), 161–169. https://doi.org/10.1037/0033-3204.31.1.161

Miller, L. (1994b). Civilian posttraumatic stress disorder: Clinical syndromes and psychotherapeutic strategies. *Psychotherapy, 31*(4), 655–664. https://doi.org/10.1037/0033-3204.31.4.655

Miller, L. (1995, May 18). *Reaching the breaking point: Are we becoming a more violent society?* CBS Action News.

Miller, L. (1996a, January 25). Evaluation and treatment of posttraumatic stress disorder in victims of violent crime. Program presented to Palm Beach County Victim Services, West Palm Beach, Florida.

Miller, L. (1996b). Making the best use of your neuropsychology expert: What every neurolawyer should know. *Neurolaw Letter, 6*, 93–99.

Miller, L. (1998a). Psychotherapy of crime victims: Treating the aftermath of interpersonal violence. *Psychotherapy, 35*(3), 336–345. https://doi.org/10.1037/h0087801

Miller, L. (1998b). *Shocks to the system: Psychotherapy of traumatic disability syndromes*. Norton.

Miller, L. (2000, January 10). Crime scene trauma: Effective modalities for victims and helpers. Workshop presented to Palm Beach County Victims Services, West Palm Beach, Florida.

Miller, L. (2001a). Crime victim trauma and psychological injury: Clinical and forensic guidelines. In E. Pierson (Ed.), *2001 Wiley expert witness update: New developments in personal injury litigation* (pp. 171–205). Aspen.

Miller, L. (2001b, September 15). Psychology in the criminal justice system: Expanding roles for mental health services. Program presented at Florida Psychological Association Continuing Education Seminar, West Palm Beach.

Miller, L. (2006a). *Practical police psychology: Stress management and crisis intervention for law enforcement*. Charles C. Thomas.

Miller, L. (2006b). *Stress management: The good, the bad, and the healthy*. https://www.police1.com/health-wellness/articles/stress-management-the-good-the-bad-and-the-healthy-ioNdI3v0t11v2AqK

Miller, L. (2007a). *May it please the court: Testifying tips for expert witnesses*. www.doereport.com/article_testifying_tips.php

Miller, L. (2007b). Traumatic stress disorders. In F. M. Dattilio & A. Freeman (Eds.), *Cognitive-behavioral strategies in crisis intervention* (3rd ed., pp. 494–527). Guilford Press.

Miller, L. (2008a). *Counseling crime victims: Practical strategies for mental health professionals*. Springer Publishing.

Miller, L. (2008b). *METTLE: Mental toughness training for law enforcement*. Looseleaf Law.

Miller, L. (2008c). Military psychology and police psychology: Mutual contributions to crisis intervention and stress management. *International Journal of Emergency Mental Health, 10*(1), 9–26.

Miller, L. (2009). Testifying in court: Practical strategies for public safety, emergency services, and mental health professionals. *International Journal of Emergency Mental Health, 11*(4), 263–269.

Miller, L. (2010). On-scene crisis intervention: Psychological guidelines and communication strategies. *International Journal of Emergency Mental Health, 12*(1), 11–19.

Miller, L. (2012). *Criminal psychology: Nature, nurture, culture*. Charles C. Thomas.

Miller, L. (2013). Law enforcement traumatic stress: Clinical syndromes and intervention strategies. In L. Territo & J. D. Sewell (Eds.), *Stress management in law enforcement* (3rd ed., pp. 565–582). Carolina Academic Press.

Miller, L. (2019). Stress, traumatic stress, and posttraumatic stress syndromes. In L. Territo & J. D. Sewell (Eds.), *Stress management in law enforcement* (4th ed., pp. 7–30). Carolina Academic Press.

Miller, L. (2020). *The psychology of police deadly force encounters: Science, practice, and policy*. Charles C. Thomas.

Miller, L., Agresti, M., & D'Eusanio, S. (1999, September 30). Posttraumatic stress disorder in victims of violent crime. WINQ Live Community Update, Lake Park, Florida.

Miller, L., & Dion, J. R. (2000). Expert spotlight: Interview with Dr. Laurence Miller. *Victim Advocate, 1*(3), 10–11.

Norris, F. H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology, 60*(3), 409–418. https://doi.org/10.1037/0022-006X.60.3.409

Palermo, G. B., & Kocsis, R. N. (2005). *Offender profiling: An introduction to the sociopsychological analysis*

Palermo, G. B., & Kocsis, R. N. (2005). *Offender profiling: An introduction to the sociopsychological analysis of violent crime*. Charles C. Thomas.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26,* 558–565. https://doi.org/10.1037/0735-7028.26.6.558

Pitts, J. (2001). The new correctionalism. In R. Matthews & J. Pitts (Eds.), *Crime, disorders, and community safety* (pp. 167–192). Routledge.

Resick, P. A. (1993). The psychological impact of rape. *Journal of Interpersonal Violence, 8*(2), 223–255. https://doi.org/10.1177/088626093008002005

Resnick, H. S., Acierno, R., & Kilpatrick, D. G. (1997). Health impact of interpersonal violence 2: Medical and mental health outcomes. *Behavioral Medicine, 23*(2), 65–78. https://doi.org/10.1080/08964289709596730

Resnick, H. S., Kilpatrick, D. G., Dansky, B. S., Saunders, B. E., & Best, C. L. (1993). Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *Journal of Consulting and Clinical Psychology, 61*(6), 984–991. https://doi.org/10.1037/0022-006X.61.6.984

Riger, S., Raja, S., & Camacho, J. (2002). The radiating impact of intimate partner violence. *Journal of Interpersonal Violence, 17*(2), 184–205.

Rothbaum, B. O., Foa, E. B., Riggs, D. S., Murdock, T., & Walsh, W. (1992). A prospective examination of posttraumatic stress disorder in rape victims. *Journal of Traumatic Stress, 5*(3), 455–475.

Rudofossi, D. (2007). *Working with traumatized police officer-patients: A clinician's guide to complex PTSD syndromes in public safety professionals*. Baywood.

Russell, H. E., & Beigel, A. (1990). *Understanding human behavior for effective police work* (3rd ed.). Basic Books.

Saunders, B. E., Kilpatrick, D. G., Resnick, H. S., & Tidwell, R. P. (1989). Brief screening for lifetime history of criminal victimization at mental health intake: A preliminary study. *Journal of Interpersonal Violence, 4*(3), 267–277. https://doi.org/10.1177/088626089004003001

Scarpa, A. (2001). Community violence exposure in a young adult sample: Lifetime prevalence and socioemotional effects. *Journal of Interpersonal Violence, 16*(1), 36–53. https://doi.org/10.1177/088626001016001003

Scarpa, A., Fikretoglu, D., Bowser, F., Hurley, J. D., Pappert, C. A., Romero, N., & Van Voorhees, E. (2002). Community violence exposure in university students: A replication and extension. *Journal of Interpersonal Violence, 17*(3), 253–272. https://doi.org/10.1177/0886260502017003002

Scarpa, A., & Haden, S. C. (2006). Community violence victimization and aggressive behavior: The moderating effects of coping and social support. *Aggressive Behavior, 32*(5), 502–515. https://doi.org/10.1002/ab.20151

Shalev, A. Y., Galai, T., & Eth, S. (1993). Levels of trauma: A multidimensional approach to the treatment of PTSD. *Psychiatry, 56*, 166–177. https://doi.org/10.1080/00332747.1993.11024631

Silbert, M. (1976). *Crisis identification and management: A training manual*. California Planners.

Silva, M. N. (1991). The delivery of mental health services to law enforcement officers. In J. T. Reese, J. M. Horn, & C. Dunning (Eds.), *Critical incidents in policing* (Rev ed., pp. 335–341). U.S. Government Printing Office.

Taylor, S., Wood, J. V., & Lechtman, R. R. (1983). It could be worse: Selective evaluation as a response to victimization. *Journal of Social Issues, 39*(2), 19–40. https://doi.org/10.1111/j.1540-4560.1983.tb00139.x

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Sage.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1–18. https://www.jstor.org/stable/20447194

Tedeschi, R. G., & Kilmer, R. P. (2005). Assessing strengths, resilience, and growth to guide clinical interventions. *Professional Psychology: Research and Practice, 36*(3), 230–237. https://doi.org/10.1037/0735-7028.36.3.230

Uhde, T. W., Boulenger, J. P., Roy-Byrne, P. P., Geraci, M. P., Vittone, B. J., & Post, R. M. (1985). Longitudinal course of panic disorder: Clinical and biological considerations. *Progress in Neuro-Pharmacology and Biological Psychiatry, 9*(1), 39–51. https://doi.org/10.1016/0278-5846(85)90178-2

Ullman, S. E. (2007). Mental health services seeking in sexual assault victims. *Women & Therapy, 30*(1–2), 61–84. https://doi.org/10.1300/J015v30n01_04

Wester, S. R., & Lyubelsky, J. (2005). Supporting the thin blue line: Gender-sensitive therapy with male police officers. *Professional Psychology: Research and Practice, 36*(1), 51–58. https://doi.org/10.1037/0735-7028.36.1.51

Wilson, J. Q., & Herrnstein, R. (1985). *Crime and human nature*. Simon & Schuster.

Yalom, I. D. (1980). *Existential psychotherapy*. Basic Books.

satisfaction of knowing that they have made a substantial impact, not just on the crime victim themselves, but on the larger radiating orbit of family, coworkers, and community.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Websites

National Center for Victims of Crime www.ncvc.org
National Organization for Victim Assistance www.trynova.org
Office for Victims of Crime http://www.ojp.usdoj.gov/ovc/help

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Asken, M. J. (1993). *PsycheResponse: Psychological skills for optimal performance by emergency responders*. Regents/Prentice Hall.

Berntsen, D., & Rubin, D. C. (2007). When a trauma becomes a key to identity: Enhanced integration of trauma memories predicts posttraumatic stress disorder symptoms. *Applied Cognitive Psychology, 21*, 417–431. https://doi.org/10.1002/acp.1290

Bidinotto, R. J. (1996). *Criminal justice? The legal system vs. individual responsibility*. Foundation for Economic Education.

Blau, T. H. (1994). *Psychological services for law enforcement*. Wiley.

Bonanno, G. A. (2005). Resilience in the face of potential trauma. *Current Directions in Psychological Science, 14*(3), 135–138. https://doi.org/10.1111/j.0963-7214.2005.00347.x

Bowman, M. L. (1997). *Individual differences in posttraumatic response: Problems with the stress-adversity connection*. Lawrence Erlbaum Associates.

Bowman, M. L. (1999). Individual differences in posttraumatic distress: Problems with the DSM-IV model. *Canadian Journal of Psychiatry, 44*(1), 21–33. https://doi.org/10.1177/070674379904400103

Breslau, N., & Davis, G. C. (1992). Posttraumatic stress disorder in an urban population of young adults: Risk factors for chronicity. *The American Journal of Psychiatry, 149*(5), 671–675. https://doi.org/10.1176/ajp.149.5.671

Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry, 48*(3), 216–222. https://doi.org/10.1001/archpsyc.1991.01810270028003

Breslau, N., Kessler, R. C., Chilcoat, H. D., Schultz, L. R., Davis, G. C. & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 Detroit Area Survey of Trauma. *Archives of General Psychiatry, 55*(7), 626–632. https://doi.org/10.1001/archpsyc.55.7.626

Brom, D., Kleber, R. J., & Defares, P. B. (1989). Brief psychotherapy for posttraumatic stress disorders. *Journal of Consulting and Clinical Psychology, 57*(5), 607–612. https://doi.org/10.1037/0022-006X.57.5.607

Budiansky, S., Gregory, S., Schmidt, K. F., & Bierk, R. (1996, March 4). Local TV: Mayhem central. *U.S. News and World Report*, 63–64.

Bureau of Justice Statistics. (2003). *Crime in the United States, 1976–2000*. National Institute of Justice.

Bureau of Justice Statistics. (2006). *Criminal victimization in the United States, 2005*. U.S. Department of Justice.

Calhoun, L. G., & Tedeschi, R. G. (1999). *Facilitating posttraumatic growth*. Lawrence Erlbaum Associates.

Clark, S. (1988). The violated victim: Prehospital psychological care for the crime victim. *Journal of*

Clark, S. (1988). The violated victim: Prehospital psychological care for the crime victim. *Journal of Emergency Medical Services*, 48–51.

Conklin, J. E. (1992). *Criminology* (4th ed.). Macmillan.

Davis, G. C., & Breslau, N. (1994). Post-traumatic stress disorder in victims of civilian trauma and criminal violence. *The Psychiatric Clinics of North America, 17*(2), 289–299. https://doi.org/10.1016/S0193-953X(18)30115-1

Durham, T. W., McCammon, S. L., & Allison, E. J. Jr. (1985). The psychological impact of disaster on rescue personnel. *Annals of Emergency Medicine, 14*(7), 664–668. https://doi.org/10.1016/S0196-0644(85)80884-2

Elliott, D. M., Mok, D. S., & Briere, J. (2004). Adult sexual assault: Prevalence, symptomatology, and sex differences in the general population. *Journal of Traumatic Stress, 17*(3), 203–211. https://doi.org/10.1023/B:JOTS.0000029263.11104.23

Everly, G. S. (1994). Short-term psychotherapy of acute adult onset post-traumatic stress. *Stress Medicine, 10*(3), 191–196. https://doi.org/10.1002/smi.2460100309

Everly, G. S. (1995). The neurocognitive theory of post-traumatic stress: A strategic metatherapeutic approach. In G. S. Everly & J. M. Lating (Eds.), *Psychotraumatology: Key papers and core concepts in post-traumatic stress* (pp. 159–169). Plenum Press.

Everstine, D. S., & Everstine, L. (1993). *The trauma response: Treatment for emotional injury*. W. W. Norton & Company.

Falsetti, S. A., & Resnick, H. S. (1995). Helping the victims of violent crime. In J. R. Freedy & S. E. Hobfoll (Eds.), *Traumatic stress: From theory to practice* (pp. 263–285). Plenum Press.

Frank, E., & Stewart, B. D. (1984). Depressive symptoms in rape victims: A revisit. *Journal of Affective Disorders, 7*(1), 77–85. https://doi.org/10.1016/0165-0327(84)90067-3

Frederick, C. J. (1986). Post-traumatic stress responses to victims of violent crime: Information for law enforcement officials. In J. T. Reese & H. A. Goldstein (Eds.), *Psychological services for law enforcement* (pp. 341–350). U.S. Government Printing Office.

Fry, W. F., & Salameh, W. A. (Eds.). (1987). *Handbook of humor and psychotherapy*. Professional Resource Exchange.

Fullerton, C. S., McCarroll, J. E., Ursano, R. J., & Wright, K. M. (1992). Psychological responses of rescue workers: Firefighters and trauma. *The American Journal of Orthopsychiatry, 62*(3), 371–378. https://doi.org/10.1037/h0079363

Garbarino, J. (1997). *Raising children in a socially toxic environment*. Jossey-Bass.

George, L. K., Winfield, I., & Blazer, D. G. (1992). Sociocultural factors in sexual assault: Comparison of two representative samples of women. *Journal of Social Issues, 48*(1), 105–125. https://doi.org/10.1111/j.1540-4560.1992.tb01160.x

Golding, J. M., Siegel, J. M., Sorenson, S. B., Burnam, M. A., & Stein, J. A. (1989). Social support sources following sexual assault. *Journal of Community Psychology, 17*(1), 92-107. https://doi.org/10.1002/1520-6629(198901)17:1<92::AID-JCOP2290170110>3.0.CO;2-E

Hays, K. F., & Brown, C. H. (2004). *You're on! Consulting for peak performance*. American Psychological Association.

Henry, V. E. (2004). *Death work: Police, trauma, and the psychology of survival*. Oxford University Press.

Herman, S. (2002). Law enforcement and victim services: Rebuilding lives together. *The Police Chief, 69*(5), 34–37.

Herrnstein, R. J., & Murray, C. (1994). *The bell curve: Intelligence and class structure in American life*. Free Press.

Horowitz, M. J. (1986). *Stress response syndromes* (2nd ed.). Jason Aronson.

Hough, M. (1985). The impact of victimisation: Findings from the British Crime Survey. *Victimology, 10*(1–4), 498–511.

Jacobson, E. (1938). *Progressive relaxation*. University of Chicago Press.

Janik, J. (1991). What value are cognitive defenses in critical incident stress? In J. Reese, J. Horn, & C. Dunning (Eds.), *Critical incidents in policing* (pp. 149–158). U.S. Government Printing Office.

Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life*. Hyperion.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2), 144–156. https://doi.org/10.1093/clipsy.bpg016

Kanazawa, S. (2004). General intelligence as a domain-specific adaptation. *Psychological Review, 111*(2), 512–523. https://doi.org/10.1037/0033-295X.111.2.512

Kanazawa, S. (2008). Theft. In J. D. Duntley & T. K. Shackelford (Eds.), *Evolutionary forensic psychiatry: Darwinian foundations of crime and law* (pp. 160–175). Oxford University Press.

Kanazawa, S., & Kovar, J. L. (2000). Why men commit crimes (and why they desist). *Sociological Theory,*

Kanazawa, S., & Still, M. C. (2000). Why men commit crimes (and why they desist). *Sociological Theory, 18*(3), 434–447. https://doi.org/10.1111/0735-2751.00110

Kilpatrick, D. G., & Acierno, R. (2003). Mental health needs of crime victims: Epidemiology and outcomes. *Journal of Traumatic Stress, 16*(2), 119–132. https://doi.org/10.1023/A:1022891005388

Kirwin, B. R. (1997). *The mad, the bad, and the innocent: The criminal mind on trial—tales of a forensic psychologist*. Little, Brown and Company.

Kushner, M. G., Riggs, D. S., Foa, E. B., & Miller, S. M. (1993). Perceived controllability and the development of posttraumatic stress disorder (PTSD) in crime victims. *Behavior Research and Therapy, 31*(1), 105–110. https://doi.org/10.1016/0005-7967(93)90048-Y

Macy, R. J. (2007). A coping theory framework toward preventing sexual revictimization. *Aggression and Violent Behavior, 12*(2), 177–192. https://doi.org/10.1016/j.avb.2006.09.002

Marra, T. (2005). *Dialectical behavior therapy in private practice: A practical and comprehensive guide*. New Harbinger.

Matsakis, A. (1994). *Post-traumatic stress disorder: A complete treatment guide*. New Harbinger.

McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. Brunner/Mazel.

Miller, L. (in press-a). *Criminal psychology: Concepts and applications*. AB Longman/Pearson.

Miller, L. (in press-b). Psychotherapy with military personnel: Lessons learned, challenges ahead. *International Journal of Emergency Mental Health*.

Miller, L. (1989a). To beat stress, don't relax: Get tough! *Psychology Today, 23*(12), 62–63.

Miller, L. (1994a). Biofeedback and behavioral medicine: Treating the symptom, the syndrome, or the person? *Psychotherapy, 31*(1), 161–169. https://doi.org/10.1037/0033-3204.31.1.161

Miller, L. (1994b). Civilian posttraumatic stress disorder: Clinical syndromes and psychotherapeutic strategies. *Psychotherapy, 31*(4), 655–664. https://doi.org/10.1037/0033-3204.31.4.655

Miller, L. (1995, May 18). *Reaching the breaking point: Are we becoming a more violent society?* CBS Action News.

Miller, L. (1996a, January 25). Evaluation and treatment of posttraumatic stress disorder in victims of violent crime. Program presented to Palm Beach County Victim Services, West Palm Beach, Florida.

Miller, L. (1996b). Making the best use of your neuropsychology expert: What every neurolawyer should know. *Neurolaw Letter, 6*, 93–99.

Miller, L. (1998a). Psychotherapy of crime victims: Treating the aftermath of interpersonal violence. *Psychotherapy, 35*(3), 336–345. https://doi.org/10.1037/h0087801

Miller, L. (1998b). *Shocks to the system: Psychotherapy of traumatic disability syndromes*. Norton.

Miller, L. (2000, January 10). Crime scene trauma: Effective modalities for victims and helpers. Workshop presented to Palm Beach County Victims Services, West Palm Beach, Florida.

Miller, L. (2001a). Crime victim trauma and psychological injury: Clinical and forensic guidelines. In E. Pierson (Ed.), *2001 Wiley expert witness update: New developments in personal injury litigation* (pp. 171–205). Aspen.

Miller, L. (2001b, September 15). Psychology in the criminal justice system: Expanding roles for mental health services. Program presented at Florida Psychological Association Continuing Education Seminar, West Palm Beach.

Miller, L. (2006a). *Practical police psychology: Stress management and crisis intervention for law enforcement*. Charles C. Thomas.

Miller, L. (2006b). *Stress management: The good, the bad, and the healthy*. https://www.police1.com/health-wellness/articles/stress-management-the-good-the-bad-and-the-healthy-ioNdI3v0t11v2AqK

Miller, L. (2007a). *May it please the court: Testifying tips for expert witnesses*. www.doereport.com/article_testifying_tips.php

Miller, L. (2007b). Traumatic stress disorders. In F. M. Dattilio & A. Freeman (Eds.), *Cognitive-behavioral strategies in crisis intervention* (3rd ed., pp. 494–527). Guilford Press.

Miller, L. (2008a). *Counseling crime victims: Practical strategies for mental health professionals*. Springer Publishing.

Miller, L. (2008b). *METTLE: Mental toughness training for law enforcement*. Looseleaf Law.

Miller, L. (2008c). Military psychology and police psychology: Mutual contributions to crisis intervention and stress management. *International Journal of Emergency Mental Health, 10*(1), 9–26.

Miller, L. (2009). Testifying in court: Practical strategies for public safety, emergency services, and mental health professionals. *International Journal of Emergency Mental Health, 11*(4), 263–269.

Miller, L. (2010). On-scene crisis intervention: Psychological guidelines and communication strategies.

Miller, L. (2010). On-scene crisis intervention: Psychological guidelines and communication strategies. *International Journal of Emergency Mental Health, 12*(1), 11–19.

Miller, L. (2012). *Criminal psychology: Nature, nurture, culture*. Charles C. Thomas.

Miller, L. (2013). Law enforcement traumatic stress: Clinical syndromes and intervention strategies. In L. Territo & J. D. Sewell (Eds.), *Stress management In law enforcement* (3rd ed., pp. 565–582). Carolina Academic Press.

Miller, L. (2019). Stress, traumatic stress, and posttraumatic stress syndromes. In L. Territo & J. D. Sewell (Eds.), *Stress management in law enforcement* (4th ed., pp. 7–30). Carolina Academic Press.

Miller, L. (2020). *The psychology of police deadly force encounters: Science, practice, and policy*. Charles C. Thomas.

Miller, L., Agresti, M., & D'Eusanio, S. (1999, September 30). Posttraumatic stress disorder in victims of violent crime. WINQ Live Community Update, Lake Park, Florida.

Miller, L., & Dion, J. R. (2000). Expert spotlight: Interview with Dr. Laurence Miller. *Victim Advocate, 1*(3), 10–11.

Norris, F. H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology, 60*(3), 409–418. https://doi.org/10.1037/0022-006X.60.3.409

Palermo, G. B., & Kocsis, R. N. (2005). *Offender profiling: An introduction to the sociopsychological analysis of violent crime*. Charles C. Thomas.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*, 558–565. https://doi.org/10.1037/0735-7028.26.6.558

Pitts, J. (2001). The new correctionalism. In R. Matthews & J. Pitts (Eds.), *Crime, disorders, and community safety* (pp. 167–192). Routledge.

Resick, P. A. (1993). The psychological impact of rape. *Journal of Interpersonal Violence, 8*(2), 223–255. https://doi.org/10.1177/088626093008002005

Resnick, H. S., Acierno, R., & Kilpatrick, D. G. (1997). Health impact of interpersonal violence 2: Medical and mental health outcomes. *Behavioral Medicine, 23*(2), 65–78. https://doi.org/10.1080/08964289709596730

Resnick, H. S., Kilpatrick, D. G., Dansky, B. S., Saunders, B. E., & Best, C. L. (1993). Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *Journal of Consulting and Clinical Psychology, 61*(6), 984–991. https://doi.org/10.1037/0022-006X.61.6.984

Riger, S., Raja, S., & Camacho, J. (2002). The radiating impact of intimate partner violence. *Journal of Interpersonal Violence, 17*(2), 184–205.

Rothbaum, B. O., Foa, E. B., Riggs, D. S., Murdock, T., & Walsh, W. (1992). A prospective examination of posttraumatic stress disorder in rape victims. *Journal of Traumatic Stress, 5*(3), 455–475.

Rudofossi, D. (2007). *Working with traumatized police officer-patients: A clinician's guide to complex PTSD syndromes in public safety professionals*. Baywood.

Russell, H. E., & Beigel, A. (1990). *Understanding human behavior for effective police work* (3rd ed.). Basic Books.

Saunders, B. E., Kilpatrick, D. G., Resnick, H. S., & Tidwell, R. P. (1989). Brief screening for lifetime history of criminal victimization at mental health intake: A preliminary study. *Journal of Interpersonal Violence, 4*(3), 267–277. https://doi.org/10.1177/088626089004003001

Scarpa, A. (2001). Community violence exposure in a young adult sample: Lifetime prevalence and socioemotional effects. *Journal of Interpersonal Violence, 16*(1), 36–53. https://doi.org/10.1177/088626001016001003

Scarpa, A., Fikretoglu, D., Bowser, F., Hurley, J. D., Pappert, C. A., Romero, N., & Van Voorhees, E. (2002). Community violence exposure in university students: A replication and extension. *Journal of Interpersonal Violence, 17*(3), 253–272. https://doi.org/10.1177/0886260502017003002

Scarpa, A., & Haden, S. C. (2006). Community violence victimization and aggressive behavior: The moderating effects of coping and social support. *Aggressive Behavior, 32*(5), 502–515. https://doi.org/10.1002/ab.20151

Shalev, A. Y., Galai, T., & Eth, S. (1993). Levels of trauma; A multidimensional approach to the treatment of PTSD. *Psychiatry, 56*, 166–177. https://doi.org/10.1080/00332747.1993.11024631

Silbert, M. (1976). *Crisis identification and management: A training manual*. California Planners.

Silva, M. N. (1991). The delivery of mental health services to law enforcement officers. In J. T. Reese, J. M. Horn, & C. Dunning (Eds.), *Critical incidents in policing* (Rev ed., pp. 335–341). U.S. Government Printing Office.

Taylor, S., Wood, J. V., & Lechtman, R. R. (1983). It could be worse: Selective evaluation as a response to victimization. *Journal of Social Issues, 39*(2), 19–40. https://doi.org/10.1111/j.1540-4560.1983.tb00139.x

victimization. *Journal of Social Issues, 39*(2), 19–40. https://doi.org/10.1111/j.1540-4560.1983.tb00139.x

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Sage.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1–18. https://www.jstor.org/stable/20447194

Tedeschi, R. G., & Kilmer, R. P. (2005). Assessing strengths, resilience, and growth to guide clinical interventions. *Professional Psychology: Research and Practice, 36*(3), 230–237. https://doi.org/10.1037/0735-7028.36.3.230

Uhde, T. W., Boulenger, J. P., Roy-Byrne, P. P., Geraci, M. P., Vittone, B. J., & Post, R. M. (1985). Longitudinal course of panic disorder: Clinical and biological considerations. *Progress in Neuro-Pharmacology and Biological Psychiatry, 9*(1), 39–51. https://doi.org/10.1016/0278-5846(85)90178-2

Ullman, S. E. (2007). Mental health services seeking in sexual assault victims. *Women & Therapy, 30*(1–2), 61–84. https://doi.org/10.1300/J015v30n01_04

Wester, S. R., & Lyubelsky, J. (2005). Supporting the thin blue line: Gender-sensitive therapy with male police officers. *Professional Psychology: Research and Practice, 36*(1), 51–58. https://doi.org/10.1037/0735-7028.36.1.51

Wilson, J. Q., & Herrnstein, R. (1985). *Crime and human nature*. Simon & Schuster.

Yalom, I. D. (1980). *Existential psychotherapy*. Basic Books.

CHAPTER 15

Traumatic Aftermath of Homicide and Suicide

JAYNA BONFINI

CHAPTER OVERVIEW

This chapter focuses on the loss, grief, and trauma that survivors may experience in the aftermath of a homicide or suicide. The chapter examines the various effects of homicide and suicide and discusses treatment strategies for working with survivors.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Understand the impact of homicides and suicides on survivors;
2. Develop empathy concerning multiple losses;
3. Discern the potential effect of COVID-19 pandemic isolation on homicide and suicide rates;
4. Identify the diagnostic considerations associated with the loss of a loved one through homicide or suicide; and,
5. Understand the treatment strategies that are most relevant to survivors of homicide and suicide.

INTRODUCTION

There is no way that anyone can prepare for the loss of a loved one through homicide or suicide. These events leave tremendous pain and suffering in their wake. The suddenness, the violence, and the preventability of such deaths complicate and compound the grieving process for survivors. Mental health professionals are positioned uniquely to assist clients in dealing with these traumatic losses, to process their grief, and to minimize the secondary victimization that many survivors experience after a homicide or suicide. This chapter

victimization that many survivors experience after a homicide or suicide. This chapter reviews the literature describing the impact of homicide and suicide on those left behind. Treatment issues and strategies for working with survivors are also discussed.

TRAUMA OF HOMICIDE

Each year, over 19,000 people die due to homicide in the United States (Centers for Disease Control and Prevention [CDC], 2017). The Center for Victim Research estimates that approximately 64,000 to 213,000 experience homicide co-victimization each year, which translates to a range of 20 to 70 people per 100,000 annually who are surviving the loss of a murdered loved one (Bastomski & Duane, 2019, pp. 3–4). While few studies measuring the national prevalence of homicide co-victimization exist, we know that every homicide leaves behind family members and loved ones—survivors and co-victims—whose lives are forever changed (Bastomski & Duane, 2019; Spungen, 1998). Losing a loved one to homicide may result in psychological trauma that shatters a person's sense of security and well-being.

Family Survivors

Family members may make sense of their loved one's murder in their own way. Some may try to get back to "normal"; others might not, as they realize the need for a new normal. There may be traumatic reminders throughout the grieving process, and dealing with the criminal justice system often may cause survivors to relive the horror (Spungen, 1998). Some traumatic reminders include news accounts of the murder or similar events; seeing or identifying the murderer; holidays, birthdays, or anniversaries of the loved one's death; and the occurrence of life events that the deceased will never experience (e.g., driving a car, walking their daughter down the aisle, celebrating a child's first steps). Other reactions and contextual factors that affect family members include inexplicability, social stigma, and involvement with the criminal justice system.

Inexplicability

The horror and disbelief of hearing of a loved one's murder is beyond comprehension. It is an ugly situation to process, and individuals often demand to know every piece of information around the death, in order to try to make sense of the situation. Survivors often experience dissociation, or a disruption in how their minds handle information. They may feel disconnected from thoughts, feelings, memories, and surroundings. Survivors often ask the same five questions: (1) What happened? (2) Why did this happen? (3) Why did I act as I did then? (4) Why did I act as I have since then? And (5) What if this happens again? (Figley, 1985, p. 404).

Social Stigma

The way the person died often determines the aftermath of the murder. For example, if a victim engaged in high-risk behavior before the murder (e.g., addiction, gang membership), survivors may feel isolated from others and disenfranchised from their ability to grieve the loss, because others believe that the victim put themselves at risk. In fact, the victim and the victim's family may be blamed irrationally for the murder, as "if only they did X, their loved one would still be alive." This reinforces the assumption of their own personal invulnerability and that people get what they deserve. However, as we know, this is a façade and tragedy can befall any family.

Involv[illegible]nal Justice System

Pleas, motions, hearings, trials, sentencings, appeals, and other aspects of involvement with the criminal justice system can be overwhelming to survivors of homicide. Each step of the legal process can bring strong emotions to surface and cause emotional distress. For example, in cases where there is sufficient evidence for a jury to find the defendant guilty, family members may feel that the sentence was not long enough. Plea bargaining, which dominates the criminal process in the United States, can bring a great deal of frustration to

dominates the criminal process in the United States, can bring a great deal of frustration to homicide survivors (Reed & Caraballo, 2021). Finally, in cases where the killer is unknown or where there is insufficient evidence for a guilty verdict, the survivor may feel even more helpless or angry.

Multiple Losses

Victims of violent crime frequently experience more than one traumatic event in their lifetimes (Saunders, 2003). Furthermore, criminal victimization is correlated with demographic factors such as racial/ethnic status and socioeconomic status, which represent risk factors for psychiatric disorders (Kilpatrick & Acierno, 2003). Therefore, it sometimes is difficult to attribute psychiatric symptoms to a particular traumatic event. More studies are needed that control for risk factors such as demographic variables and prior trauma history, in order to better understand the effects of traumatic events like homicide victimization. Box 15.1 illustrates one person's experience with multiple losses.

BOX 15.1

Case Illustration: Susan

Susan is a 58-year-old woman, married for 35 years to Rick, 59. They have two grown children: Jeremy, 28, and Natalie, 24. Susan works as a reading specialist at a local elementary school, and her husband owns a landscaping business. The family is close-knit, and during the busy summer months of Rick's business, the whole family worked together on landscaping projects and routine maintenance.

Late one evening, police officers rang the family's doorbell and informed Susan and Rick that Jeremy had been murdered. Susan does not recall what happened in the next moment, and the hours and days after receiving the news are missing from her memory. She went with Rick to choose a casket and plan a funeral, but she reports that she cannot tell you who attended the funeral, what was said, or even what she wore. She asked, "What are you supposed to wear to your child's funeral anyway?"

Susan began to be aware of feelings and sensations as the initial shock began to subside. Her appetite was nonexistent, and she was unable to sleep for more than an hour or two at most. Susan had recurrent nightmares of Jeremy asking for help or calling out to her asking why he died. Susan would wake up shaking and wracked with a sense of guilt that she had been unable to help and protect her son. She took a leave of absence from work until the end of the academic year.

Rick, concerned for Susan's health, was able to convince her to leave the home and visit a doctor. Susan's doctor prescribed medication to help with sleep and depressive symptoms. Susan began to regain her strength and emotional stability, as she was able to rest and recover from her profound loss.

When an arrest was made, a month later, Susan and Rick were told that the case against the alleged perpetrator was strong and that a trial date would be in 6 months. Susan and Rick were informed by the district attorney that the trial would start on a particular date. However, when they arrived, they learned that, at the last minute, the trial had been postponed. This was very frustrating to both Susan and Rick, who were hoping for a sense of closure, as well as justice for Jeremy.

When the trial finally commenced, Susan found it difficult to observe images from the crime scene and had to leave the courtroom temporarily. She found it difficult to breathe and had thoughts of Jeremy's suffering in his final moments. A guilty verdict was ultimately returned, and Susan, Rick, and Natalie prepared victim impact statements to express their pain and injuries as a result of Jeremy's murder. The killer was sentenced to prison, for 20 years, for murder in the second degree.

Once the legal case was closed, Susan thought her life would return to "normal," or as close to normal as she could imagine, but without Jeremy. Unfortunately, the trial brought up some of the feelings, nightmares, and anxiety that she experienced during the time after Jeremy's funeral. Her flashbacks worsened, and her sleep suffered; she also became

Jeremy's funeral. Her flashbacks worsened, and her sleep suffered, she also became reclusive, spending days in Jeremy's childhood bedroom surrounded by his photos, old sports trophies, and other items that reminded her of him. Rick, again concerned, called their family doctor who referred Susan to a trauma counselor.

The trauma counselor, Tamara, diagnosed Susan with posttraumatic stress disorder (PTSD). During the initial assessment, Tamara discovered that Susan blamed herself for Jeremy's death, because she had encouraged him to move into his own apartment the year prior. Susan wanted him to be more independent and to live as a young adult and not a "perpetual teenager" in her home. Tamara was able to reframe this distortion for Susan and began a course of Eye Movement Desensitization and Reprocessing (EMDR) to help Susan cope with the traumatic images. Tamara also referred Susan to a psychiatrist to obtain medication to help relieve the symptoms of hypervigilance and avoidance that she was experiencing.

Susan's symptoms subsided over time, and after more than a year, Susan felt that she was ready to take what she had learned about this process and help others in similar situations. Susan worked with another homicide survivor to start a local support group aimed at helping other families and friends to navigate the thoughts, feelings, and sensations that surround such a seismic loss.

TRAUMA OF SUICIDE

Suicide long has been considered a global public health problem, with about 800,000 people taking their lives each year (World Health Organization [WHO], 2019). It is a complex and multidimensional phenomenon. Individuals who attempt suicide frequently describe feelings of hopelessness, despair, and social isolation as triggers for acting on suicidal impulses (Feigelman & Feigelman, 2008). According to WHO data, each suicide is accompanied by more than 20 suicide attempts (WHO, 2019). In 2019, the most recent year that full data are accessible from the CDC, the number of deaths totaled 47,511 in the United States. It is in the top 10 causes of death across all age groups and the second-leading cause of death in persons under the age of 34 (CDC, 2017).

The literature describes suicide as affecting between five nuclear family members and 80 relatives, friends, and acquaintances (Andriessen et al., 2017; Berman, 2011). A meta-analysis by Andriessen et al. (2017) found that 4.3% of people have experienced a suicide in the previous year, with 21.8% being exposed to suicide during their lifetimes. This makes suicide a highly pervasive phenomenon, with the group of suicide survivors being one of the largest at-risk communities for mental health disorders. Suicide survivors show increased risk of complicated grief, depressive and anxiety disorders, substance-abuse disorders, and suicidal behavior (Jordan & McIntosh, 2011).

Grieving suicide survivors are a particular group of individuals. Grief is the natural reaction to the loss of someone significant, as the survivor processes emotional, psychological, physical, and behavioral responses to the death (Jordan & McIntosh, 2011). However, people grieving suicide loss also present an important component of shock and possible trauma, as well as feelings of abandonment, rejection, unacceptance, and shame related to the circumstances of death (Jordan & McIntosh, 2011).

Family Survivors

When a loved one is murdered, there is often a desire for an explanation; the question "Why?" emerges. Why did this happen? However, when a loved one dies by suicide, the "Why?" question is coupled with the question of responsibility. In homicide, the horrific intent of the murderer might explain what happened; this intent, coupled with actions, certainly points to responsibility, especially in the court of law. However, the responsibility question is not always so clear with respect to suicide. Jordan (2020) explains that most survivors begin by blaming themselves for the death. "Many survivors repeatedly review a litany of their own 'sins of omission and commission' in trying to assign responsibility for the death" (Jordan, 2020).

Table 15.1

Relationship Loss Issues for Survivors of Suicide

Loss of a Child	Loss of a Parent	Loss of a Sibling	Loss of a Spouse/Partner
• Rejection • Guilt • Shame • Blame • Stigma • Fear of exposure as failure • Anger	• Abandonment • Legacy of suicide • Children acting out in grief • Secondary loss of surviving parent • Guilt • Responsibility • Blame • Parentification	• Loss of victim as well as parent(s) • Added family responsibility • Anger • Blame parent for failure • Overresponsibility • Parentification	• Abandonment • Rejection • Blame • Survivor guilt • Anger • Stigma • Others blame spouse • Expectations of others

Those who are left behind in the wake of a suicide are left trying to understand how to deal with an inexplicable act. They are left to mourn a parent, child, or sibling who was a part of their life since the moment they were born, or to mourn a spouse whose love and life they shared, or to grieve their very best friend and companion. In his 2020 article summarizing his 40 years of experience working with suicide survivors, John Jordan outlined the mourning process after a suicide and how it differs from more normative causes of death. First, there is a greater need to seek an explanation for the death and to make sense of the death (Jordan, 2020). Second, survivors experience greater levels of guilt and felt responsibility for the death, or, at a minimum, for a failure to somehow foresee and prevent the suicide (Jordan, 2020). Third, there is a greater level of stigmatization and shame about this mode of death, and a greater need to conceal the fact that the death was a suicide (Jordan, 2020). Fourth, survivors receive more avoidance by, and isolation from, social support from their regular social networks (Jordan, 2020). And, fifth, exposure to the loss of a loved one to suicide increases the chances of suicidal thinking and behavior in the person exposed (Jordan, 2020).

The type of relationship that was lost influences the reactions of the survivor. Because the needs, responsibilities, hopes, and expectations associated with each type of relationship vary, the personal meanings and social implications of each type of death also differ. Table 15.1 demonstrates relationship loss issues that may arise when a loved one dies by suicide, as highlighted in Flatt's (2007) Suicide Survivors' Support Group Guide.

Loss of a Child

Katrina Fuller lost her son, Landon, 11, to suicide in late April 2020, after the schools were closed across the country and stay-at-home orders imposed to minimize the spread of COVID-19. The closures were hard on many people; for some, it was completely destabilizing. Landon took the shutdowns especially hard (MacGillis, 2021). He was an outgoing kid who loved school, enjoyed attending church, and liked riding bikes with his friends in the neighborhood. He was lonely and had written in his journal that the lockdowns were driving him crazy and that all he wanted was to go to school and play outside with his friends (MacGillis, 2021). It was too much for him to bear. As Katrina and her family tried to recover from this loss, several months later, a letter arrived at the grieving family's home. It was a form letter from the state Public Education Department indicating that Landon had been truant from his online classes in Fall 2020 (MacGillis, 2021). Her sadness turned to anger at the insensitive oversight.

Katrina started hearing from other families from around the country, including a mother of a 6-year-old. "These are kids without mental health issues, with good families, kids that are loved," Katrina said. "I've heard it all," Fuller said with respect to explanations. "I've blamed myself" (MacGillis, 2021).

Parents who lose a child experience unique circumstances that can intensify and prolong the mourning process. They struggle to make sense as to why their 11-, 15-, 19-, or 25-year-old child did not ask them for help. Sometimes there are warning signs of the person's

intentions. However, clues may be so disguised that even a trained professional may not recognize them. Occasionally there are no discernible signs, and the child's suicide becomes a catastrophic decision that may never be understood. While mental illness often plays a role in suicide, not everyone who dies by suicide is mentally ill (Stone et al., 2018). For every family that has experienced years of treatments, hospitalizations, and medications with their child, others experience none at all.

Loss of a Parent

In the wake of a parent suicide, many children and young teens are devastated and "experience profound grief, guilt, and anxiety that may persist for months and even years" (Jamison, 1999, p. 302). Losing a parent to suicide at an early age is often a catalyst for the child's own psychiatric disorders and even suicide; however, it is the simultaneous developmental, environmental, and genetic factors, which come together, that increase the risk for also dying by suicide (Wilcox et al., 2010). Children can be surprisingly resilient, and research demonstrates that a supportive environment and attention to any emergent mental health symptoms may offset even such a major stressor as a parent's suicide (Cohen et al., 2006; Jamison, 1999; Janet Kuramoto et al., 2009; Wilcox et al., 2010). Like other trauma survivors, there may be a critical window for intervention in the aftermath of a parent's suicide, during which clinicians carefully can monitor and refer children for psychiatric evaluation and, if needed, residential care (Wilcox et al., 2010).

Siblings

People who lose a sibling to suicide often experience anger, complicated grief reactions, depression, posttraumatic stress disorder, and even thoughts of taking their own lives (Bolton et al., 2017). Until recently, these survivors were overlooked in medical research, However, according to several studies of survivors, those who lose a sibling to suicide, especially one of the same sex or close in age, have more serious mood disorders and thoughts of suicide themselves than survivors who lose a sibling for any other reason (Bolton et al., 2017; Royden, 2019). It might be difficult, as well, for siblings to find support within their families, as they are struggling with the loss, and in some families, siblings feel that they should not show their pain for the sake of their parents (Royden, 2019).

Spouse

Companionship in many marriages consists of sharing daily routines, responsibilities, and bed and often the sharing of intimate lives. In all cases, the death of a spouse to suicide necessitates that the survivor find substitute companions or tolerate a lonelier life. In addition to dealing with the traumatic loss, the surviving spouse is left with unfamiliar tasks to be accomplished. For example, the loss of a spouse may mean the loss of the family's chief income producer, which then imposes on the survivor a need to manage the household finances and to compensate for the spouse's absence. This is especially difficult if the couple has young children to support.

Writing in *Night Falls Fast: Understanding* ***Suicide***, Jamison (1999) recounts a woman's experience after the death of her husband: "The guilt and 'if onlys' escalated and seemed to be endless, especially for me. My husband's parents, who were very close to us before the suicide, blamed me for my husband's depression and refused to enter our home" (p. 302). In this way, the couple's children lost both their father and their paternal grandparents to suicide.

Survivors experience greater levels of guilt and felt responsibility for the death (or at a minimum, for a failure, somehow, to foresee and to prevent the suicide). There is a greater level of stigmatization and shame about this mode of death, and a greater need to conceal the fact that the death was a suicide. In her aforementioned book, Jamison (1999) recounts a story of the denial of suicide. One of her colleagues, an eminent scientist, suffered from bipolar disorder and killed himself. His wife refused to belief that he had died by suicide and forbade it from being mentioned at his funeral or memorial service. She unknowingly "made

it very hard for his fellow professors, graduate students, and laboratory staff to deal with his death and move on with their lives. Even a year later, his students and colleagues found it difficult to discuss the suicide" (Jamison, p. 299).

There is an expression in the support community that goes along the lines of "No one brings you a casserole when your family member dies by suicide" (or when your loved one is an addict or has another stigmatized mental health diagnosis). Survivors experience more avoidance by, and isolation from, their supports and from their regular social networks. Additionally, as in other sudden, unexpected, and often violent deaths such as homicide, suicide also seems to produce higher levels of PTSD-type symptoms such as avoidance and hyperarousal (Bonanno et al., 2007). This often is accompanied by a significant disruption of the survivors' assumptive world (e.g., beliefs such as "my life is predictable" and "I can keep my loved ones safe from harm" (Parkes, 2001, 2013).

CURRENT RESEARCH: COVID-19'S IMPACT

At the time of this writing, we do not yet know the full impact of COVID-19 in terms of homicide and suicide survivors as a full report of the 2020 data is not yet available. However, COVID-19 brought together extreme cases of social isolation and/or unrest and economic unease against a background of fragile and undersupported public health systems. With such risk factors, it is unsurprising that the homicide and suicide rates increased during 2020—as well as the ranks of survivors left behind. Indeed, this pandemic fundamentally has disrupted the ways in which survivors process death and grieving. In-person funerals have been replaced by scaled-down or virtual events. Relatives and friends expressing condolences often have provided them via a smartphone screen instead of in person.

In a recent report by the National Commission on COVID-19 and criminal justice, homicide rates in a sample of 34 cities were 30% higher in 2020 than in 2019, a jump that claimed an additional 1,268 lives in those cities alone. Rosenfeld et al. (2021) said that urgent action is needed to address the increase, including subduing the pandemic, improving police legitimacy, and expanding proven antiviolence programs in cities hardest hit by crime.

While homicide rates in 2020 were higher than 2019 levels during every month of the year, the rise was steepest in June, coinciding with mass protests after the May 25 killing of George Floyd by a Minneapolis police officer. The three largest cities in the sample, New York, Los Angeles, and Chicago, accounted for 40% of the 1,268 additional murder victims in 2020 (Rosenfeld et al., 2021). Rosenfeld et al. (2021) reported that "While there is variation among the cities, what is most notable is that homicide rose substantially in the vast majority of them" (p. 18). Overall, a rise in murders of this magnitude suggests that the increase in the national homicide rate is likely to exceed the previous largest single-year increase of 13% in 1968 (Rosenfeld et al., 2021). That determination, however, cannot be verified until official crime statistics are released by the federal government in late 2021. It should be noted that homicide has dropped significantly in the United States since the early 1990s, although brief spikes occurred in 2005, 2006, 2015, and 2016. Even with the 2020 increases, the homicide rate for the cities in the Rosenfeld et al. study was just over half of what it was for those same cities 25 years ago (11.4 deaths per 100,000 residents in those cities versus 19.4 per 100,000 in 1995) (Rosenfeld et al., 2021).

Suicide and COVID-19

The compulsory lockdowns for people during the spring of 2020 confined nearly half of the world's population to their households. This lockdown, to stop the spread of COVID-19, led to a decrease in contacts and deprived individuals from their support and care structures as people received help only for basic daily needs. During this time, Pinto et al. (2020) explained, "Emotional and affective support was scarce, with a marked increase in feelings of loneliness and isolation" (p. 2). Even prior to COVID-19, the suicide rates had been climbing, in addition to rising rates of anxiety, depression, and substance abuse. During the week of June 24, 2020, CDC data showed that younger adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse

mental health outcomes, increased substance use, and elevated suicidal ideation (Czeisler et al., 2020). Alarmingly, nearly a quarter of young adults experienced suicidal thoughts (Czeisler et al., 2020).

The full data set for 2020 is not yet completed; sadly, it seems that 2020 will be another year of suicide increases (Czeisler et al., 2020). If these trends continue, or if it will be a 1 or 2 year increase due to the pandemic, only time will tell. We know that some of the strategies that successfully have prevented homicides and suicide in the past are not available until the vaccines become more widespread, and society resumes a semblance of normalcy. However, in the meantime, mental health, medical care, and services for justice-involved individuals require a great deal of face-to-face contact, typically among service providers and the people who are most likely both to commit these offenses and to be the victims of them. Not everyone has the capability to engage in telehealth and videoconferencing, and this makes it difficult for those who cannot meet in person.

DIAGNOSTIC CONSIDERATIONS

Intense grief is typical, after we lose someone close, and remains intense until we adapt to the loss. For an estimated 10% to 15% of bereaved people in the general population, adaptation is problematic (Bryant, 2013). The rates for bereaved people experiencing difficulty in adapting are higher when the death is sudden, unexpected, or violent, such as in homicide and suicide (Bastomski & Duane, 2019). Evidence indicates that many survivors are diagnosed with posttraumatic stress disorder (PTSD), depression, suicidal ideation, and/or complicated grief as a result of their experiences.

Posttraumatic Stress Disorder

As individuals, we often have the deepest connections with those that we love—these relationships help make us who we are. They contribute to our sense of identity and have the power to transform us, for good or bad. Because of this, the death of a loved one can create numerous psychological issues, including the development of PTSD, particularly if the loss is tragic and unexpected. By definition, PTSD can occur when someone has experienced, witnessed, or been confronted with a terrible event. News of an unexpected death already brings up especially strong emotions, because it catches us off guard. A tragic death magnifies these feelings. In fact, a 2014 study by Keyes et al. (2014) noted that, "unexpected death was associated consistently with elevated odds of new onsets of PTSD, panic disorder, and depressive episodes at all stages of the life course." The symptoms of PTSD (American Psychiatric Association, 2013; Mitchell & Terhorst, 2017) include:

- Being frequently angry, tense, or jumpy;
- Physical symptoms like heart palpitations, sweating, or hyperventilating;
- Flashbacks of the trauma or dwelling on what the person might have gone through in their final moments;
- Persistent avoidance of things or events that remind us of the person or place where the tragedy occurred;
- Avoiding the emotions surrounding the death or event;
- Problems sleeping or nightmares;
- Changing personal routine to avoid reminders of the event;
- Distorted feelings of guilt and blaming; and,
- Negative thoughts.

Most of the time, people slowly begin to recover from the initial shock and grief of a death. For those with PTSD, however, the symptoms dramatically affect their day-to-day lives, and they experience the symptoms for at least a month, perhaps longer. While some survivors may eventually recover on their own, it is best to seek counseling and other assistance to overcome PTSD symptoms.

Major Depressive Disorder

Major Depressive Disorder

The death of a loved one can lead to major depressive disorder (MDD; Bastomski & Duane, 2019; Bellini et al., 2018), which can be diagnosed in the fallout of a traumatic death. People with MDD experience symptoms like persistent sadness, loss of interest in activities, and sleep and appetite disturbance (American Psychiatric Association, 2013). Additionally, suicide survivors may be at an increased risk for suicide themselves, particularly if they have lost a romantic partner or child to suicide, as discussed previously. This risk is even higher if the suicide survivor has a mental health diagnosis such as PTSD or MDD (Bellini et al., 2018).

Prolonged/Complicated Grief

There is no predictable trajectory to the traumatic grief related to homicide and suicide. Acute grief symptoms—such as feelings of shock, sadness, and yearning—usually lessen in intensity over time, enabling the bereaved to reengage with life. However, approximately 10% of bereaved people find that grief persists with substantial distress and impairment for years after a loss—a condition called complicated grief (Columbia Center for Complicated Grief, 2018). Complicated grief is diagnosed when grief and related symptoms remain severe beyond the first year, interfering substantially with healthy functioning and impeding the survivor's ability to integrate the loss and move forward (Columbia Center for Complicated Grief, 2018). Risk factors for complicated grief are elevated after a traumatic loss, such as to suicide or homicide. Indeed, homicide survivors experience complicated grief at a rate two to three times higher than the general population (Columbia Center for Complicated Grief, 2018).

RELEVANT MULTICULTURAL ISSUES

It is well-established that grief due to homicide or suicide is difficult regardless of race, age, gender, or socioeconomic status. However, certain populations are more vulnerable and may be at heightened risk. Throughout the United States, homicide and its survivors are geographically concentrated in large cities (e.g., New York, Los Angeles, Chicago) with larger Black and Latinx populations and part of a broader pattern of structural inequalities (Rosenfeld et al., 2021). Black and Latinx people face an elevated risk of homicide and homicide co-victimization compared to their White counterparts (CDC, 2017). Additionally, Native Americans also face higher rates of homicide compared to Whites. Based on a lack of research that examines the rate of homicide survivorship or co-victimization among Native Americans, it is not possible to present an accurate estimate of the risk that Native Americans face (Bastomski & Duane, 2019, p. 5). We can only make an inference, based on the prevalence rates and existing literature, that the risk is elevated.

Race and ethnicity are correlated with high risk of homicide survivorship. In particular, Black adults, adolescents, and children, as well as Latinx adolescents and children, are substantially overrepresented as homicide survivors (Bastomski & Duane, 2019; Turner et al., 2018). Alarmingly, evidence suggests that homicide survivors/co-victims are concentrated among adolescents. Bastomski and Duane (2019) explain, "people are most likely to identify as a survivor during this time ... the difference in reporting could reflect variation in how younger people perceive loss" (p. 5).

Conversely, the prevalence rate for suicide is higher among White Americans, well above those for Asian Americans, Black Americans, and Hispanics (Frakt, 2020). Case and Deaton (2017) found that both White non-Hispanic men and White women are facing a mortality crisis with what they refer to as "deaths of despair" (e.g., deaths by suicide, alcohol, and drugs; p. 11). White deaths of despair have increased in all regions of the country at every level of urbanization (Case & Deaton, 2017, p. 12). The epidemic has spread from the Southwest, where it was centered in 2000, first to Appalachia and then to Florida and the west coast by the mid-2000s; it is now, unfortunately, nationwide (Case & Deaton, 2017, p. 12). Additionally, the CDC found higher suicide rates in rural America than in medium/small and large metropolitan counties. Most gun deaths in America are suicides, not murders; White men are more likely to own a gun (CDC, 2017; Frakt, 2020).

Protective factors such as the Christian or Catholic faith for Black Americans and the Latinx populations, respectively, and kinship responsibilities held by Asian Americans may keep their suicide prevalence and survivorship rate lower than Whites (Frakt, 2020). This is despite lower unemployment and other markers of success (Frakt, 2020).

TRAUMA-INFORMED TREATMENT STRATEGIES

Survivors of suicide and homicide face unique challenges that can impede the normal grieving process. As mentioned in an earlier section, this puts survivors at an increased risk for developing complicated grief, MDD, PTSD, and suicidal ideation. If left untreated, these conditions can lead to prolonged suffering, impaired functioning, negative health outcomes, and even fatalities. There are several effective treatment therapies for addressing significant mental health disorders after the sudden or traumatic death of a loved one, including cognitive behavioral therapy (CBT), EMDR, and somatic experiencing. Sometimes medications are used in conjunction with these modalities.

Cognitive Behavioral Therapy

A tragedy and the resulting trauma may alter survivors' thinking as they try to process what happened. For example, they might feel overwhelming guilt, as if they were somehow responsible for the event. Or they may feel detached from the world or from those they love. These negative thoughts can cause avoidance of the things normally enjoyed, or they can cause survivors to worry obsessively that they may lose someone else in a similar manner. Initially developed by Aaron Beck in 1964, CBT focuses on the relationship among thoughts, feelings, and behaviors, and notes how changes in one domain may improve functioning in the others (Beck, 1976). Altering a person's unhelpful or faulty thinking may lead to healthier coping and improved emotional regulation.

Counselors using CBT encourage clients to evaluate their thinking patterns and assumptions in order to identify unhelpful patterns in thoughts, such as overgeneralizing bad outcomes and applying this type of overgeneralization to all situations. By using CBT, clients learn to overcome the kind of negative thinking that diminishes anything positive or even neutral, and that positions clients to expect catastrophic outcomes. Counselors aim for their clients to achieve a more balanced and effective pattern of thought. The intention is to help clients to reconceptualize their understandings of traumatic experiences, as well as their understanding of themselves and their ability to cope (Monson & Shnaider, 2014). Additionally, clients are exposed to the trauma narrative, whereby they are reminded of the emotions associated with the traumatic loss. This helps clients to reduce avoidance and

maladaptive associations with the trauma in a controlled and measured way, working collaboratively with the counselor at the client's own pace (Monson & Shnaider, 2014).

Eye Movement Desensitization and Reprocessing

EMDR helps people to process trauma on an emotional level. With PTSD, traumatic thoughts and memories work against the brain's healing process. Flashbacks, nightmares, and disturbing emotions cycle through the brain, keeping the ordeal in the forefront of the person's mind. EMDR therapy can break that cycle by using bilateral (both sides of the body) stimuli to tap into the biological mechanisms that the brain uses during rapid eye movement (REM) sleep (Shapiro & Maxfield, 2002). The theory is that using REM, while recalling the disturbing thoughts or memories of the trauma, helps the brain to process it naturally, allowing the mind to heal. A therapist might use such bilateral stimulation as hand-tapping, eye movements (e.g., following a pattern of lights, following fingers moving back and forth), vibrations, and musical tones.

More than 30 positive controlled outcome studies have been done on EMDR therapy. Some of the studies show that 84% to 90% of single-trauma victims no longer have posttraumatic stress disorder after only three 90-minute sessions. Another study, funded by the HMO Kaiser Permanente, found that 100% of the single-trauma victims and 77% of multiple-trauma victims no longer were diagnosed with PTSD after only six 50-minute sessions (EMDRIA, 2021). Given the large research base demonstrating EMDR's effectiveness for the treatment for trauma, it is well-regarded by organizations such as the American Psychiatric Association and the World Health Organization (EMDRIA, 2021).

Somatic Experiencing®

The Somatic Experiencing method is a body-oriented approach to recovery from trauma and other stress disorders. Created by Levine (1997), Somatic Experiencing releases traumatic shock to transform emotional trauma. It differs from cognitive therapies in that its major interventional strategy involves bottom-up processing by directing the client's attention to internal sensations, both visceral and muscular-skeletal, rather than to primarily cognitive or emotional experiences (Payne et al., 2015). Somatic Experiencing specifically avoids direct and intense evocation of traumatic memories and instead approaches the charged memories indirectly and gradually.

Family Therapy

In addition to individual therapy, family therapy may be helpful for those attempting to reconstruct their worldview after a homicide or suicide. The goal of family therapy, in the aftermath of homicide and suicide, is to assist the loved ones in the completion of unfinished business between themselves and those whom they lost. It also is helpful to recognize the remaining roles and relationships in the family that have been left behind.

Counselors who work with families are aware of the diversity of family dynamics that must be addressed and accommodated in treatment. This applies to reactions to tragedy as well. Vesper and Cohen (1999) describe five types of family reactions in the face of traumatic loss, including in the case of criminal victimization and its aftermath. The "contemptuous family" copes with adversity by getting upset, berating and blaming each other, and/or denying the existence of problems. Counselors may have to start with getting family members to communicate over small matters before addressing big issues like their common loss. The "brittle family" members are reluctant to depend on one another for support; they prefer to rely on outsiders for care and concern. The counselor may take advantage of this and serve as a bridge to connect family members. The "hierarchical family" functions with a sense of internal unity and purpose. However, it has little flexibility, and specific family members—usually the older persons or eldest child—make the decisions. While this structure can inject an element of order and stability to chaos, the risk is that the cohesion may crumble if the hierarchy breaks down. The counselor should encourage flexibility in decision-making. The "enduring family" relies on religious faith to deal with tragedy. They expect that God deems

"enduring family" relies on religious faith to deal with tragedy. They expect that God deems the consequences that are appropriate, and that challenges sometimes will occur that are part of a greater plan. As long as this remains a healthy and inclusive way of coping, counselors should reinforce meaning-making. Last, and healthiest, is the "functional family," which supports and bolsters more devastated family members while working to care for one another. For these families, the counselor's task is to encourage members to keep providing positive support (Vesper & Cohen, 1999).

Group Therapy

In her seminal work, *Trauma and Recovery*, Herman (1997) writes that while a survivors' group is a good idea, it requires careful planning by the group leader, as groups that start out with an overabundance of hope may dissolve, thereby causing additional pain. Potential group members must be screened to ensure that the modality is appropriate for all participants. Herman notes that the "destructive potential of groups is equal to their therapeutic promise" (p. 217). However, when groups are successful, survivors of homicide and suicide are given the opportunity to share feelings with others, to promote self-esteem, as they alternatively receive and provide help to others, and to find personal meaning in the traumatic events that led them there. Herman (1997) explains:

> Commonality with other people carries with it all the meanings of the word common. It means belonging to a society, having a public role, being part of that which is universal. It means having a feeling of familiarity, of being known, of communion. It means taking part in the customary, the commonplace, the ordinary, and the everyday. It also carries with it a feeling of smallness, or insignificance, a sense that one's own troubles are 'as a drop of rain in the sea.' The survivor who has achieved commonality with others can rest from her labors. Her recovery is accomplished; all that remains before her is her life. (pp. 235–236)

Peer Support Groups

Peer support groups have been founded by survivors who already have worked through many of the issues in the aftermath of homicide, and who wish to help others who are similarly situated. Support groups are a safe place for survivors to share experiences and feelings. Many survivors who recently have lost a loved one learn that others have had the same reactions to a horrific experience, and it provides them with hope that they, too, will be able to cope. A list of resources for peer support groups is located in the online version of this chapter. Box 15.2 describes a clinical pitfall that could jeopardize an attempt at counseling a client who needs services.

BOX 15.2

Clinical Pitfall

Commonly, some counselors aim to "fix" the presenting problem, as soon as possible, by using interventions that are dictated by their clinical approaches. For example, Larry, a counselor using CBT, asked his client James, a grieving widower, to "change his negative thinking" about his wife's death by suicide. While CBT can be helpful in treating survivors following a traumatic loss, Larry first must strive to create a secure attachment with James, in order to understand, fully, the long-term impact that such a loss may have on James, who had hoped to grow old with his wife. Having a theoretical underpinning is necessary in treatment. However, counselors must be patient and fully present with a client, going at the client's pace. It is difficult to work with people who are in extreme pain, and counselors must remember that the survivor does not have a choice. Survivors cannot undo what has happened to their loved ones. Counselors working with this population must tolerate the persistence of the pain of this experience and be willing to sit with clients as they work through this intense pain.

COUNSELING IMPLICATIONS

We should note that clinicians often lack experience and training in working with survivors of suicide and homicide. Indeed, many clinicians may find it overwhelming and exhausting to work with clients who are grieving. Those who work with homicide and suicide survivors must develop an ability to listen empathically to the repeated and often vivid descriptions of violent images, poignant memories, and even fantasies for revenge. Validating a client's suffering makes the counselor vulnerable to vicarious traumatization (vicarious traumatization is detailed in Chapter 30, "Vicarious Traumatization," but it is important to discuss it briefly, here, as it relates to working with homicide and suicide survivors). It is believed that counselors working with trauma survivors experience vicarious trauma because of the work that they do with individuals who are in a great deal of pain due to abnormal events. Vicarious traumatization refers to negative changes in the clinician's view of self, others, and the world, resulting from repeated empathic engagement with clients' trauma-related thoughts, memories, and emotions (Pearlman & Saakvitne, 1995).

Vicarious trauma is the emotional residue of exposure that counselors have from working with traumatized people; as counselors hear clients' trauma stories, the counselors become witnesses to the pain, fear, and terror that trauma survivors have endured (Pearlman & Saakvitne, 1995). This is not simply burnout; vicarious trauma is a state of stress, tension, and preoccupation concerning the trauma experiences described by clients. Symptoms might include an avoidance of talking or thinking about what the trauma survivor has been talking about, being numb to the client's pain, or being in a persistent state of arousal. Counselors should be aware of the signs and symptoms of vicarious trauma along with the potential emotional effects of working with trauma survivors. Counselors must be careful not to assume feelings and experiences that belong to clients. Obtaining appropriate clinical supervision and attending to self-care needs are incredibly important for counselors working with this population.

Counselor as Homicide Survivor

Losing a client to homicide is distinct from other forms of termination or bereavement, in that it is violent, transgressive, and intentional (Milman et al., 2018). Resilience is an essential component for counselors whose clients are murdered. Counselors who have a strong support network, who maintain a sense of hope and optimism, and who remember to practice self-care are more likely and better able to overcome adverse events. Bolstering resilience can allow mental health professionals to become better able to cope with such a loss and to experience posttraumatic growth following the death of a person in treatment.

Counselor as Suicide Survivor

The potential for losing a client to suicide is always a risk for mental health professionals. Whenever it happens, everyone associated with the client is affected by the tragedy. Box 15.3 presents a clinical illustration of when a counselor is the survivor of a client's suicide.

BOX 15.3

Clinical Illustration: Surviving Candice's Suicide

Candice was a 38-year old homemaker and mother of two. She was from a small town in Eastern Ohio and moved to Pittsburgh 12 years ago, when she married her husband. She initially was referred to counseling for depression, following an acrimonious divorce after her husband's affair. Candice and her ex-husband only communicated through the "Family Wizard" platform, which was monitored by the court and their attorneys; they had a strict schedule, with respect to joint custody of the two sons, ages 11 and 9. Candice believed that the male judge had sided with her ex-husband in awarding joint custody. She had wanted sole custody of their children. Instead, she had her children half of the time and her ex and his new girlfriend had them the other half. Her ex-husband objected to her receiving spousal support; however, she had not worked since they married 12 years ago, per her ex-husband's desire to have a stay-at-home spouse. To resume her teaching career, Candice

husband's desire to have a stay-at-home spouse. To resume her teaching career, Candice needed to retake qualifying examinations and other continuing education. The judge awarded 3 years of spousal support, estimating that this would be how long it would take Candice to get her career on track and support herself.

After a few months of outpatient therapy and a referral to a psychiatrist for an antidepressant, Candice's mood began to improve. She began to practice self-care, started a workout routine with other women, and embarked on a path to be recertified as a teacher. Candice talked with her counselor about taking a trip to visit family in Ohio and reconnect with old friends. However, on the day prior to her leaving, her ex-husband called their oldest son and announced that he was now engaged and that the boys would be big brothers to an eventual half-sibling. The boys would celebrate the happy news with their father and new stepmother-to-be that weekend. Candice met her ex at the designated drop-off point, as planned, that next morning. Directly after hugging her boys goodbye, Candice got in her car, drove to a bridge, and jumped off. Her counselor initially learned of her death on Facebook.

One of the tragedies of Candice's suicide is that she had been improving and charting a new path of independence, and then a setback—news of her ex-husband moving on and building a new family—leveled her. Counselors must address the aftermath of client suicide. The loss is significant, both personally and professionally. Hendin et al. (2000) surveyed 26 therapists who lost a client to suicide. They found that emotional reactions of guilt were common, as were shock, grief, fear of blame, self-doubt, shame, anger, and a sense of betrayal. Twenty-one of the 26 therapists identified at least one major change that they could have made, thinking that if only they did X or said Y, the suicide could have been prevented (Hendin et al., 2000). Some of the therapists were reluctant to accept subsequent suicidal clients into their practices as a result of the client suicide. Finally, although colleagues were supportive, institutional responses, case reviews, and debriefs were rarely helpful, as these either attributed blame or offered false reassurance that the suicide was inevitable (Hendin et al., 2000).

There is a paucity of information regarding self-care after the loss of a client to suicide. However, it is of the utmost importance, because a client's suicide can generate counselor feelings of low self-esteem, professional incompetence, and thoughts about the counselor's own mortality.

Many competent clinicians—about a quarter of all counselors (Meyers, 2015)—lose a client to suicide. We are humans first, before we are professionals, and we need to take the time to discuss our feelings and review the case with a trusted colleague, preferably one who has been in the same position. Counselors who experience a client's suicide are also at risk for mental health problems, like anyone else surviving a traumatic loss. Unfortunately, the pressures of work and lack of time often have an impact on counselors' ability to take appropriate measures for their own self-care after client suicide (Scupham & Goss, 2020). However, it is paramount for counselors to be given space to grieve, to have open communication in the workplace, and to receive peer support and supervision. For counselors in private practice, client suicide raises the need for external support to be accessible as well.

CONCLUSION

This chapter addressed the many factors surrounding the violent and sudden nature of homicide and suicide, as well as how such an event may affect a survivor's ability to cope in the aftermath. Survivors of homicide and suicide need competent counselors to help them with processing their traumatic experiences. Counselors working with this population must be prepared to listen to graphic detail and difficult emotions from grief-stricken clients, while engaging their own support systems to prevent vicarious traumatization.

ADDITIONAL RESOURCES