PROVIDING HELP TO VICTIMS:

A STUDY OF PSYCHOLOGICAL AND MATERIAL OUTCOMES

A report to the
National Institute of Justice

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CONTENTS

I. INTRODUCTION

Only a decade ago, little was know about the psychological effect of crime on it victims. Just as victims were relatively ignored in the criminal justice system (Ash, 1972; McDonald, 1976), so too were their mental health needs ignored by society. Today the situation is different. The mental health profession has recognized that crime victims can have psychological needs similar to victims of natural disasters, accidents, war, life-threatening diseases, and other catastrophes (American Psychological Association, 1984; Salasin 1981; Spates, 1981).

Many programs to help victims of crime cope have sprung up across the country. Among the services that most of these programs provide is crisis counseling--a brief therapeutic intervention to help victims to recover from the psychological and material effects of crime. But while crisis counseling is a widely used technique, little has been known about whether it is an effective tool for use with crime victims. That issue is the focus of this report.

A. Background on the Psychological Effects of Victimization

1. Early Research

Research on the psychological impact of criminal victimzation began about 1970. Studies that were done during the 1970s lacked the sophistication that has characterized some of the more recent work in the area. But the early studies were useful in pointing

out that crime could have major psychological consequences for its victims, both short- and long-term.

Rape reactions have been the best-studied of any victim responses to crime. Early research efforts in this field was often conducted by clinicians in conjunction with a treatment program. The research documented the severe trauma often experienced by rape victims including disorientation, fear, shock, anger, anxiety, humiliation, feelings of helplessness, depression, and a variety of psychosomatic reactions (Sutherland and Scherl, 1970; Notman and Nadelson, 1976; Burgess and Holmstrom, 1974 and 1976). Rape researchers found that it is not unusual for rape trauma to result in impaired functioning socially and sexually (Burgess and Holmstrom, 1979; Becker, Abel, and Skinner, 1979). Moreover they discovered the effects of rape can persist or reappear years later (Burgess and Holmstrom, 1978).

The efforts of other researchers showed that serious psychological reactions are not limited only to rape victims. Syvrud (1967) and Bourque, et. al. (1978) reported that the experience of being robbed resulted in what they termed "a state of crisis" in a sizeable minority of victims. It was noted that crisis reactions included shock, fear, confusion, and helplessness. Knudten, et. al. (1976) and Zeigenhagen (1974) found that symptoms of emotional distress, including nightmares, insomnia,

and anxiety, were the most common type of problems reported by victims of a cross-section of crimes. Even victims of property crimes are not immune from serious psychological reactions: surprisingly, Bourque, et. al. (1978) reported that burglary has a more lasting impact on victims' lives than robbery. Similar findings of long-lasting psychological efforts of burglary--including feelings of violation, mistrust of others, fear of coming home, and fear of being alone--have been reported by Waller and Okihiro (1978) and by Maguire (1980).

2. Models of Post-Victimization Reactions

As data began to accumulate on the effects of crime, some researchers and clinicians attempted to place the process of trauma and recovery within the framework of a "phase" model (e.g. Sutherland and Scherl, 1970; Burgess and Holmstrom, 1974; Bard and Sangrey, 1979). While the exact definition of each phase varies from author to author, all phase models share the idea that victims pass through several identifiable stages as a necessary condition for return to normal functioning.

The first phase, termed by Bard and Sangrey (1979) the impact stage, is said to occur immediately after the crime, when victims commonly experience feelings of shock, disbelief or numbness. Many victims blame themselves for allowing the crime to happen and/or not offering more resistance. The impact phase may last

for hours or days. During this period victims may find it difficult to eat or sleep. Disorientation and feelings of helplessness and vulnerability are common (Symonds, 1975).

The second phase, labelled the recoil phase by Bard and Sangrey, is viewed as a period in which victims begin to accept the crime, and feelings of fear, anger, and sadness are manifested. Victims who appear to be adjusting well at this point may be, according to the theory, actually denying the seriousness of the event and perhaps suppressing fears and phobic reactions. As denial wears off, victims may attempt to deal with their feelings by reliving the crime and talking about it frequently. Feelings of guilt are said to be often present during this stage.

The third stage hypothesized by phase theorists--reorganization--is a period when fear and anger decrease and victims become less preoccupied with the incident. Obsessive talking and thinking about the crime decline and victims begin to focus again on their lives.

A more recent model which has been applied to post-victimization reactions is the concept of post-traumatic stress disorder. Post-traumatic stress disorder, or PTSD, is a concept developed by clinicians working with former hostages, war veterans, and survivors of other life-threatening events who noted similarities

in the manner in which people respond to these events. Recently, the American Psychiatric Association recognized PTSD in its 1980 Diagnostic and Statistical Manual of Mental Disorders III as a new category of disorder which encompasses victims of catastrophic events.

PTSD is defined as stress resulting from an external stressor that would evoke anxiety symptoms in most people (Figley, 1985). It incorporates a range of symptoms. One is reliving the traumatic event through intrusive thoughts or nightmares. Another manifestation of PTSD is flattened affect: persons suffering from PTSD may lose interest in their normal activities, become detached from family and friends, and show little emotion. Other symptoms include, hyperalterness; sleep disturbance; impaired memory; feelings of guilt, shame or depression; phobias about activities that trigger recollection of the event; and intensification of symptoms through exposure to stimuli associated with the traumatic event.

The PTSD concept applies quite well to the more severe manifestations of distress experienced by crime victims. It has influenced many recent studies on crime victims through researchers' selection of scales such as the Impact of Event Scale (Horowitz, Wilner, and Alvarez, 1979) which are designed specifically to measure aspects of PTSD.

3. Recent Research on the Psychological Effects of Crime

Research in the 1980s on the psychological effects of crime has been characterized by increasing methodological and theoretical sophistication. It has become commonplace for studies to include standardized scales and non-victim control groups as part of their design. As a result, it has become possible to quantify in what ways and for how long victims are affected by crime, and which victims are affected most.

The effects of rape that have now been quantified include phobic reactions and general anxiety (e.g. Kilpatrick, Resick, and Veronen, 1981; Kilpatrick and Veronen, 1983; Calhoun, et al, 1982); depression (Atkeson, et al, 1982; Frank, Turner and Duffey, 1979); impaired sexual functioning (Becker and Skinner, 1983; Feldman-Summers, et. al., 1979); impaired social functionsing (Resick, et al, 1981) and reduced self-esteem (Veronen and Kilpatrick, 1980). Moreover, evidence is mounting that these reactions--especially fear and anxiety--do not necessarily disappear with the passage of time as proponents of the phase model suggested, but may persist for years.

In addition to gathering normative data on the severity and duration of post-crime trauma, recent research has also turned its attention on predicting <u>which</u> victims are at greatest risk of experiencing serious trauma. The factors examined tend to fall

into several categories, including (a) victims' ability to cope with stress, as indicated by their level of psychological functioning at the time of the crime and the occurrence of other recent stressors, (b) demographic characteristics of victims, and (c) aspects of the crime itself.

The factors most strongly related to post-crime functioning appear to be those that reflect victims' ability to cope with stress. For example, Calhoun and Atkeson (1981) found that the best predictor of depression, fear, and anxiety among rape victims one year after the crime was whether victims had been experiencing psychological problems prior to the rape. Similarily, McCahill, Meyer, and Fischman (1979) reported that victims with adjustment problems prior to the rape had more trouble adjusting after rape. And Frank, Turner, Stewart, Jacob, and West (1981) found that victims who had been treated for psychiatric problems prior to being raped had a harder time recovering from rape than other victims. On the other hand, Kilpatrick, Veronen and Best (1985) reported no effects of previous psychological difficulties or treatment on victims' adjustment three months post-rape.[1]

Another manifestation of victims' ability to cope with stress that has been examined by a number of researchers is the amount of life stress (major changes, such as death of a loved one, changing of jobs or residences, and so forth) experienced by

victims in the period prior to the crime. The guiding hypothesis usually is that victims who have experienced high levels of life stress are less equipped emotionally to cope with the effects of crime. Studies which have found a deliterious effect of prior life stress on post-crime adjustment include Harrell, Smith, and Cook (1985) and Kilpatrick, et. al. (1985). Other researchers, however, have found ambiguous relationships between life stress and psychological reactions to crime (Ruch, Chandler, and Harter, 1980).

Findings on the influence of demographic factors on post-crime adjustment have been quite mixed. Older rape victims were found to adjust less well than younger victims by Calhoun and Atkeson (1981) and McCahill, et al (1979); but age was found to have little effect on adjustment in studies by Kilpatrick, et. al. (1985) and Friedman, Bischoff, Davis and Person (1982). Married rape victims were found to have a harder time adjusting by McCahill, et al (1979) and by Ruch and Chandler (1983), but not by Kilpatrick, et. al. (1985) or by Calhoun and Atkeson (1981). More consistent are the findings that women are more traumatized by crime than men (Harrell, et. al., 1985; Friedman, et. al., 1982) and that victims with little formal education and low incomes are more traumatized than victims from higher socio-economic groups (Friedman, et. al., 1982; Harrell, et. al. 1985; Calhoun and Atkeson, 1981). Moreover, the relative

importance of SES as a predictor of adjustment has been found to be greater after several months have passed than shortly after the crime. In other words, victims who are economically well off recover relatively quickly, while those who are less affluent continue to show signs of distress months later.

Aspects of the crime itself (degree of violence, use of weapons, threats to victims' lives) appear to be only weakly predictive how quickly victims adjust. Little or no effect of characteristics of the crime were observed by Atkeson, et. al. (1982), Frank, et. al. (1981), Ruch and Chandler (1983), or Kilpatrick, et. al. (1985).[2] However, one factor which does have a major effect on post-crime adjustment is the type of crime itself. Harrell, et. al. (1985) reported that trauma varied with an index of crime severity. And Friedman, et. al. (1982) found that robbery and asssault victims had a more difficult time in several areas of adjustment than did burglary victims.

Another focus of current research on victims is the relationship between how people perceive their victimization and their ability to readjust in the weeks and months after the crime. One aspect of how people perceive victimization centers around blame for the incident. "Just world" research, pioneered by Lerner and his associates (e.g. Lerner, 1970; Lerner and Simmons, 1966) has long suggested that other people, as well as victims themselves, tend to blame victims for their misfortune. Crisis theorists in

the victim field (e.g. Bard and Sangrey, 1979) have noted this and have argued that such perceptions are detrimental to victims' recovery. On the other hand, Wortman (1976) raised the question of whether it might be adaptive for victims to blame themselves for the incident. Several years later, Janoff-Bulman (1979) drew a distinction between characterological self-blame (blaming the events on stable aspects of one's personality that cannot easily be changed) and behavioral self-blame (blaming the event of specific behaviors that can readily be altered). Janoff-Bulman suggested that, while characterological self-blame was a hinderance to recovery, behavioral self-blame might facilitate recovery by giving the victim a greater sense of control. Positive effects of self-blame were found in a recent study by Baum, Fleming and Singer (1983). In a study of the aftermath of the accident at the Three Mile Island Nuclear Plant, they found that nearby residents reported less stress if they blamed themselves for problems experienced after the accident than if they blamed external sources. Thus, it appears that self-blame is related to recovery, but there is not as yet a consensus on exactly how they are related.

Another theory of how people perceive victimization comes from a recent paper by Taylor, Wood, and Lichtman (1983). They propose that victims attempt to minimize their situation through a process of "selective evaluation." According to the authors,

this process takes five forms, including (a) comparing oneself with less fortunate others, (b) focusing on attributes that make one appear advantaged, (c) comparing one's situation to worse possible situations, (d) identifying positive consequences in the situation, and (e) positively evaluating one's coping efforts. With some qualification, Taylor, et. al. argue that the selective evaluation process is adaptive. This belief receives some empirical support from Silver, Boon, and Stones (1983) who found that, for incest victims, finding meaning in one's victimization--a process not too dissimilar to Taylor, et. al.'s process of identifiying positive consequences of victimization - reduced psychological distress and facilitated social adjustment. On the other hand, Wortman (1983) reviews studies by Derogatis, Abeloff, and Melisaratos (1979) and Litman (1962) which show that focusing on the positive can retard recovery. These studies found that physically ill patients with the most negative attitudes toward themselves and their illness fared better than those with positive attitudes. Wortman interprets this result to mean that distaste for one's concept of oneself in a debilitated post-crisis state can be a powerful motivator for recovery.

B. Programmatic Responses to the Psychological Effects of Victimization

Reports of researchers and clinicians on the psychological consequences of crime soon led to the establishment of programs to help victims. The now-defunct Law Enforcement Assistance Administration (LEAA) was one of the first federal agencies in the early 1970's to sponsor the development of projects to improve the treatment of victims by criminal justice officials and to provide services designed to help victims recover. Between fiscal years 1970 and 1975 LEAA spent more than 22 million dollars for these projects. These early efforts have served as the basis for the establishment and growth of a wide variety of victim assistance programs throughout the country.

According to a survey by Cronin and Bourque (1981), a majority of victim programs provided crisis counseling services designed to lessen the adverse aftereffects of crime. The authors reported that, at the time of their survey, more than 400 jurisdictions across the country had some form of crisis intervention program available to assist crime victims.

The term, "crisis intervention", implies that victimization is a crisis, viz. an event which cannot be interpreted or coped with by use of the victim's normal problem-solving capacities (Bard and Ellison, 1974; Brodyaga et. al., 1975; Stratton, 1976).

In other words, the technique is one which is designed to aid persons who normally function successfully, but who are experiencing temporary adjustment problems because of a well-defined stressful situation. The technique is one which was developed in other fields (suicide prevention, serious illness, death of loved ones), but which seems quite appropriate for crime victims.

Crisis intervention, as defined by Aguilera and Messick (1978), consists of the following components:

- Determining the extent of the crisis and the precipitating event.
- Planning therapeutic intervention; determine what the individual's coping skills are what other resources are available to help.
- Executing the intervention plan, including (a) helping individuals to understand the crisis intellectually, (b) helping individuals to probe and understand their feelings, (c) helping individuals to adopt coping strategies, and (d) aiding individuals to reopen their social world.
- Resolving the crisis and discussing strategies for handling future crises.

Crisis counseling typically involves compassionate listening, helping the victim to make sense of the event and helping the victim to obtain other social services (American Psychological Association, 1984). In the crime victim field, crisis intervention services often include material assistance such as emergency food, shelter, clothing, or cash; home security or crime preven-

tion services; and other services designed to help victims regain a sense of control over their lives.

But, while crisis intervention has been widely applied to the treatment of crime victims, there is relatively little data on whether it is effective in helping victims to recover. In their 1981 survey of victim assistance programs, Cronin and Bourque decried the lack of evaluative data on crisis intervention services. While noting that clients tend to report that program services are helpful, Cronin and Bourque conclude, "Most strikingly, no studies have yet examined whether project clients suffer less trauma either in the short or long run, than victims who go without help" (1982:29).

When the American Psychological Association's Task Force on the Victims of Crime and Violence issued its final report in 1984, they found that the situation had changed little. The Task Force report states bluntly, "Both those who seek help and those who pay for services deserve interventions for which the efficacy is known or is under systematic study. Little is know about the effectiveness of services currently being offered to victims" (1984:100).

In fact, though, some studies on the effects of counseling with victims of crime have begun to appear in the literature. With one exception, however, they have not focused on the crisis

intervention model that most victim programs use, but rather have examined the effects of cognitive-behavioral therapies on rape victims. Kilpatrick (1984) reported two treatment studies, both involving small numbers of victims. In the first study, 50 rape victims were randomly assigned to either a Brief Behavioral Intervention procedure (in which they received 4-6 hours of relaxation training, explanations of rape-related problems, and presentation of coping skills) or one of two control groups. When assessed 3 months after the rape, distress scores for both treated and untreated victims had improved significantly, but there was no greater improvement for the treated victims.

In the second study, Kilpatrick and his colleagues administered to 11 rape victim volunteers 20 hours of "stress innoculation training" (a set of techniques for fear management including muscle relaxation, breath control, role playing, covert modelling, stoppage of negative thoughts, and self-guided dialogue). Victims who completed the training (most who started dropped out) showed lower levels of fear and anxiety when measured immediately after therapy completion and three months after completion than they had exhibited on a pre-training measure. Unfortunately, without a control group of any sort, it is impossible to decide whether the technique was effective, whether simply the attention paid to the victims was effective, or whether the decline in distress was purely a function of the passage of time.

Frank and Stewart (1984) reported on another study using cognitive/behavioral therapies with a small number of rape victims. In their study, 42 women were randomly assigned either to a condition in which they received 14 hours of "systematic desensitization" (a technique which teaches victims to employ relaxation methods in situations that elicit stronger and stronger amounts of fear) or 14 hours of "cognitive restructuring" (a technique which ferets out and challenges "irrational" beliefs about the world, one's self and others which are assumed to give rise to adjustment problems). Victims who completed both treatments showed marked improvement on measures of adjustment. Once again, however, since a no-treatment control group was not included, and since victims do tend to recover over time in any event, it is not certain whether the therapy per se was responsible for improvement in victims' psychological states.

Becker, Skinner, Abel, and Cichon (1984) administered 10 hours of sex therapy to victims of sexual assault. Sixty-eight women were randomly assigned to one of four conditions: (a) immediate individual therapy, (b) immediate group therapy, (c) delayed individual therapy, or (d) delayed group therapy. The authors reported some short-term advantage for victims immediately receiving therapy relative to the delayed-treatment controls on measures of sexual functioning but not on measures of depression, relationship adjustment, or fear. The short-term

advantages of treated victims tended to disappear, however, three months after therapy, especially among victims who received individual therapy. These ambiguous results are made still more unclear by the facts that (a) the therapy was very ecclectic, with the therapists deciding which of a variety of components to administer to individual victims and (b) by the failure of the authors to specify key features of the method and analysis (such as time elapsed between pre- and post-tests for controls or demonstration of pre-treatment equivalency of treated versus control victims).

The largest study of counseling outcomes--and the first to examine the crisis counseling model--was conducted by the Institute for Social Analysis (ISA) with funds from the National Institute of Justice. ISA's study (Smith and Cook, 1985) was of the Pima County Victim/Witness Advocate Program in Tucson, Arizona, a program which provides on-site crisis intervention services to victims of all types of crimes when summoned to the scene of a crime by the police. Smith and Cook's study used a quasi-experimental design which compared victims for whom the police had summoned a victim worker to the scene to victims for whom the police had not requested a victim caseworker.

Surprisingly, Smith and Cook found that the group which had received victim program services scored significantly worse on measures of anxiety, fear, stress and behavioral adjustment

shortly after they received on site crisis intervention than victims who did not receive such services. Several months later, the group receiving project services was no longer exhibiting greater distress than the control group--but neither was it exhibiting any less distress. The authors concluded that, "Despite the victims' feelings that the program helped them considerably, the measures of emotional trauma did not indicate any substantial effects" (1984:103).

Smith and Cook also noted, however, a serious flaw in their design--a flaw which may have made it impossible to detect beneficial effects of the program. Originally, the authors believed that the police decision of whether to summon victim caseworkers to the crime scene was more or less random. However, that turned out be far from the case: In fact, the program service and control groups were composed of very different types of victims. The group that received project services had a far higher proportions of rapes, robberies, and assaults, while the no-service group had more victims of domestic violence. Smith and Cook concluded that, "the police called in the victim assistance crisis unit for the most severely traumatized victims."

Of the few studies of the outcomes of victim counseling that have been done to date, only the one by Smith and Cook has focused on the crisis counseling model which is widely used with victims of all types of crime. Moreover, there is little

indication from research to date that counseling of any sort is effective in reducing post-crime trauma. Given the infancy of the field, that is hardly surprising: the situation is little better in other areas of crisis intervention (see for example, the discussion of crisis counseling outcome research in the fields of suicide prevention, acute psychiatric crises, and surgical patients in Auerbach and Kilmann, 1978). And, it has only been in recent years that the weight of evidence has begun to suggest that even longer-term therapy for psychological problems is more effective than no treatment (Smith, Glass, and Miller, 1980). The effects of counseling are simply not easy to measure, and the methodological problems involved in trying to measure them are substantial. Still, much money is being spent on crisis intervention services for victims, and--as the American Psychological Association's Task Force suggested--those who receive services and those who pay for them certainly have a need to know which forms of treatment work and which do not.

C. The Present Study

The present study focuses on crisis intervention services provided by the Victim Services Agency (VSA) in New York City. Established in 1978, VSA is the largest victim services program in the country, with an annual budget in 1985 of ten million dollars. Through nine neighborhood offices located throughout the boroughs of New York City, VSA last year provided crisis intervention services to more than 5,400 victims.

While the scale of VSA's crisis services are different than other victim programs, the nature of the services are similar. Services provided by VSA's neighborhood offices include crisis counseling; emergency financial assistance; emergency shelter; lock repair and security checks; assistance with filing claims with the state victim compensation board; document replacement; and assistance to victims in dealing with criminal justice and social service agencies. VSA does not, however, provide services at the site of the crime as does the Pima County program studied by Smith and Cook. Rather, clients of VSA's neighborhood offices are referred by other organizations or are brought in through outreach letters to victims who file criminal complaints with the police. In not providing services at the scene of the crime, VSA is probably more typical of victim programs than the Pima County Victim/Witness Advocate Program studied by Smith and Cook.

The current research grew out of VSA's interest in knowing whether the crisis counseling it was providing was effective in helping victims to recover from the psychological effects of crime. Also, because VSA places a heavy emphasis on material assistance, the Agency was interested in knowing whether those services played a demonstrable role in victims' recovery. Finally, VSA was interested to know if other counseling techniques might be used in conjunction with the traditional crisis

counseling approach that it normally used to make a stronger treatment. One technique that seemed particularly promising was the cognitive restructuring method that was used in the study by Frank and Stewart (1984).

VSA's research proposed, therefore to examine the effects of three service conditions on the post-crime adjustment of victims of a variety of crimes. The three service conditions, or "treatments", included: (a) traditional crisis counseling (which incorporates psychological and material assistance), (b) cognitive counseling (used in conjunction with crisis counseling), and (c) material assistance only (no psychological first aid provided. In a fourth, no-treatment condition, victims received no services. Detailed descriptions of each of these conditions are contained in the next chapter.

The original design did not call for random assignment of victims to treatments, but rather for a quasi-experimental design similar to that used in ISA's study of the Pima County program. Especially after ISA's experience, however, it was felt that random assignment was the only way to ensure pre-treatment comparability between groups. But random assignment posed another problem--it seemed unethical to withhold Agency services from victims in the control group who would normally receive Agency services. This problem was circumvented by recruiting victims (by letter and by phone) from police felony complaint

records in precincts adjacent to several of the precincts in which VSA had neighborhood offices--that is, in areas in which victims were not receiving VSA services, but which were close enough to VSA offices that it was convenient for victims to travel to the offices to be interviewed. (The solution to this problem, however, spawned other difficulties which are discussed in the next chapter.)

The design implemented, then, randomly assigned victims recruited from police felony complaint records in eight New York City precincts to one of four treatment conditions. Victims in all conditions were administered an assessment battery including measures of mood, post-traumatic stress disorder, general psychopathology, fear of crime, and social adjustment. Victims were assessed through an in-person interview twice, once prior to treatment and once afterwards. The initial interviews were conducted within the first month after the crime, and the follow-up interviews three months later. All together, 249 victims completed the first interview and 188 of the victims also completed the follow-up interview.

Chapter 2 of the report presents the method used in the study and evaluates its weaknesses as well as its strengths. Chapter 3 presents evidence from pre- and post-treatment assessments about the effects that services had upon victims' psychological and material adjustment. Chapter 4 discusses the reactions of

counselors to being trained in and using the cognitive technique selected for the study. Chapter 5 looks at factors that predict how well victims adjust both in the short-and long-term. The final chapter summarizes what was learned in the study and the implications of the findings both for providing services and for future research.

Chapter I Footnotes

1. Although the same study did find that self-esteem, arguably another indication of victims' coping ability, did affect post-rape adjustment.

2. But see also the finding of McCahill, et. al. (1979) on the relationship between the brutality of rapes and long-term adjustment.

II. METHOD

A. Overview and Genesis of the Research Design as Adopted

The original study design called for comparing a sample of 125 victims of robbery, assault, and burglary who received crisis intervention services with a control sample of 125 victims not offered services. Victims in the crisis intervention sample were to be drawn from among victims who filed crime complaints with the police in five New York City precincts served by VSA neighborhood offices and who received crisis intervention services from those offices. Victims in the control sample were to be recruited from persons who filed complaints in five precincts not served by VSA offices (these precincts were to be matched demographically to the precincts served by VSA). Victims in both groups were to be psychologically assessed twice--shortly after the crime (prior to receiving crisis intervention services for the VSA sample) and again two months after the crime.

The design as originally formulated was a quasi-experimental design. Such a design is not as powerful as a true experimental design, in which services would be withheld or delayed on a random assignment basis from some victims who presented themselves to VSA for assistance. But denying services to needy victims who would normally receive them raises ethical questions.

Prior to beginning the study, the research staff learned of the serious difficulties that the Institute for Social Analysis

had into using a quasi-experimental design, in its evaluation of crisis intervention services in Pima County, Arizona. The problem ISA had experienced--a crisis-intervention group that was far more traumatized than the control group--was likely to be even more pronounced in the New York City study: Victims who receive VSA's crisis intervention services represent only a small proportion (less than 5%) of all victims who file complaints in the precincts served by VSA neighborhood offices. These victims--presumably highly traumatized--would have been compared to a sample drawn from the pool of all victims who filed complaints in the control precincts.

For these reasons, the original study design was reconsidered and a new design drawn up, one which did incorporate random assignment of victims to treatments. In order to circumvent the ethical issue of denying or postponing crisis intervention services to some victims who would otherwise receive them, the design called for recruiting all victims (those who received services as well as controls) from felony complaints in precincts not served by VSA neighborhood offices. The precincts from which victims were recruited were chosen because they were adjacent to precincts with VSA offices, since victims who agreed to participate were asked to travel to VSA offices to be interviewed.

The new study design also expanded the number of experimental conditions compared from two to four. One of the new conditions

added was a Material Assistance Only treatment in which victims received the material assistance that was normally a part of VSA's crisis services, but did not receive counseling. The other added condition was a Cognitive Restructuring treatment in which victims were counseled using a cognitive approach taught to VSA crisis intervention workers by a therapist acting as consultant to the study.

Finally, the revised design called for follow-up assessment of victims at three, rather than two, months post-crime. This change was made in order to permit comparison to other studies using standardized measures to assess victims at similar post-crime intervals.

The new design was presented to a meeting of the study's advisory panel on March 14, 1984 and was subsequently approved by NIJ.

B. The Study Setting

The study was carried out with the cooperation of four VSA service locations in New York City. While the study did not draw on clients of these sites, the offices did provide facilities for research staff to set up and conduct interviews, as well as counselors who provided the crisis or cognitive counseling to indicated study participants.

Three of the study sites were neighborhood offices, including one in the Kingsbridge area of the Bronx, one in Jamaica, Queens and one in Harlem in the borough of Manhattan. The fourth site was VSA's main office in lower Manhattan.

Although each office provides essentially similar services of counseling and material assistance each has a fair degree of local autonomy. As a result, emphases change from one office to another, depending upon the training and clinical philosophy of the director. The Harlem office, for example, was reputed to emphasize material assistance more than the other sites while the Kingsbridge office was believed to place the strongest emphasis on victims' psychological needs. Preliminary research for the present study yielded data which reinforce these notions of differences in office philosophies[1]. While the average number of counseling sessions per client was quite low in all offices examined, Harlem and Jamaica had a substantially lower number of sessions per client (1.5 and 1.3, respectively) than the Kingsbridge office (2.3 sessions per client).

Although the study was not dependent upon the offices for client recruitment, differences in clientele and emphases between the offices are nonetheless important because they help to shape the clinical orientation of counselors who volunteered to participate in the study. This is especially true since VSA had no centralized training for counselors, and new clinical staff were, therefore, trained by a supervisor at the local sites.

At each study site, victims were recruited from two police precincts adjacent to the precinct served by the local VSA office. The precincts included in the study were the 40th and 44th (Kingsbridge office), 110th and 112th (Jamacia office), 23rd and 25th (Harlem office), and 6th and 9th (VSA main office).

C. Description of Treatments Used in the Study

1. Crisis Counseling

Crisis intervention techniques focus on the resolution of immediate, crisis-related problems rather than long-standing emotional disorders. Client-counselor contacts are few in number, usually one to six sessions (Auerback and Kilman, 1977). Crisis counselors begin by planning the therapeutic intervention, including a determination of the individual's coping skills and resources available to help. The counselor then plays an active role, helping individuals to understand the crisis and their reactions to it, assisting individuals in developing strategies for coping with the crisis, and marshalling resources (e.g. social service agencies, legal assistance and family members) to aid the client (Aguilera and Messick, 1978).

Crisis intervention as practiced at VSA loosely follows the above form. There is a strong emphasis on material assistance (see below). With respect to psychological counseling, a clinical psychologist who acted as a consultant for the study observed

that sessions usually included the following elements:

- Venting

  Clients are encouraged to talk about the circumstances and feelings relating to the crime.

- Explanation of typical reactions of victims

  Clients are often told that their own seemingly confused or upsetting reactions have been experienced by others, and are normal, given the circumstances.

- Reassurance

  Victims are told that they will recover and be able to cope with their life circumstances even though they are upset at present.

As previously mentioned, however, local autonomy of office directors tend to produce some differences in counseling approaches. Differences in orientation also result from differences in counselors' formal educations: Of the eight counselors who participated in the study, two held M.S.W. degrees, four held bachelors degrees in social work and two did not have college degrees. Despite this diversity among staff, counseling at VSA falls within the parameters of the crisis counseling technique described above.

For the crisis counseling condition, counselors were simply instructed to provide counseling and material assistance to study participants as they would to their usual clients. During the first half of study intake (i.e., the first 120 victims sampled) all victims randomly assigned to counseling received the crisis counseling treatment. During the second half of the intake period, all victims assigned to counseling received the cognitive restructuring technique described below.

2. Cognitive Restructuring

Cognitive-behavioral therapy has enjoyed a growing popularity with clinicans during the past 20 years. As early as 1955 Albert Ellis introduced psychotherapeutic techniques designed to correct distorted thought patterns that he believed contributed to emotional disturbance. More recently, Aaron Beck has developed cognitive therapy techniques for depression (Beck, 1976; Beck, Rush, Shaw and Emery, 1979), after writing about the influence of thinking on depression for over 20 years (Beck, 1963, 1964, 1967). Seligman and his colleagues (Overmeier and Seligman, 1967; Seligman and Maier, 1967) developed and later revised (Abramson, Seligman, and Teasdale, 1979; Seligman, Abramson, Semmel, and VonBaeyer, 1979) a theory of depression based on animal research on the concept of "learned helplessness." Meichenbaum (1977) has developed two different cognitive techniques, one intended primarily marily for use with impulsive children ("self-instructional training") and the other for use in preparing to face stressful situations ("stress innoculation"). Another cognitive model posits that attributions of events and behavioral reinforcements are the principal variables involved in maintaining depression (Rehm, 1977; Fuchs and Rehm, 1977; Rehm, 1979).

Common to each of these techniques is the notion that maladaptive thought patterns contribute to emotional disturbance. It is argued that thinking distortions filter experiences in

habitually negative ways, so that an individual's view of himself, the world, and the future are quite pessimistic (Beck, et. al., 1979). An often-used quotation by cognitive therapists is from Epicetus: "Men feel disturbed not by things, but by the views which they take of them." Long lasting improvement can be obtained only by changing the negative thinking patterns to positive ones.

Cognitive therapy has been the subject of much study (Kendall, 1982 and 1984; c.f. the journal devoted to the topic for the last decade, Cognitive Therapy and Research). It has been shown to be effective in a wide variety of circumstances from depression (Comas-Diaz, 1981; Vezina and Bourque, 1984; Taylor and Marshall, 1977) to adolescent problems (Bedrosian, 1981) to problem drinking (Oei and Jackson, 1984). Some studies have directly compared cognitive therapy with other treatments, including pharamcological treatment (Rush, Beck, Kovacs, and Hollon, 1977) or psychodynamically-oriented psychotherapy (Mclean and Hakstian, 1979) and found cognitive superior. These studies have been conducted with varied groups of subjects including low income Puerto Rican women, hospital in-patients, adolescents, and senior citizens.

The particular form of cognitive behavior therapy adopted in the study was the cognitive restructuring technique described by Beck, et. al. (1979). Cognitive restructuring is a method for

disputing irrational and dysfunctional beliefs which, it is assumed, give use to a host of negative emotions. For crime victims such emotions might include anxiety, depression, feelings of guilt or low self-worth, feelings of vulnerability, hostility directed toward some group, etc. Altering irrational beliefs should reduce negative emotions and speed victim's recovery.

The technique employed in the study involves the use of a "Situation Chart" (contained in Figure 2.1), similar to forms used by Aaron Beck and Albert Ellis to help clients analyze their problems and correct dysfunctional beliefs. In a counseling session, the counselor probes for maladaptive behaviors or emotions that the victim may be experiencing. Once such responses are uncovered, the counselor uses the form to expose irrational thoughts that may underly these responses, asking the victm to fill in the appropriate columns on the form as the session progresses.

For example, a burglary victim might feel very anxious and uncomfortable whenever she is alone in her apartment. In the "Situation" column on the form she would fill in "Being home alone", and under the "Feelings" column, she would fill in "Felt very anxious". The counselor would explore with her the thought process that gave rise to her anxiety: Perhaps this might be: "someone might break in when I am home and harm me." This would be written down in the "Automatic Thoughts" column. Next, the

"FIGURE 2.1: COGNITIVE RESTRUCTURING SITUATION CHART"

DATE	SITUATION Describe: 1. Actual event leading to unpleasant emotion, or 2. Stream of thoughts, daydream, or recollection, leading to unpleasant emotion.	EMOTION(S) 1. Specify sad/ anxious/angry, etc. 2. Rate degree of emotion, 1-100.	AUTOMATIC THOUGHT(S) 1. Write automatic thought(s) that preceded emotion(s). 2. Rate belief in automatic thought(s), 0-100%.	RATIONAL RESPONSE 1. Write rational response to automatic thought(s). 2. Rate belief in rational response, 0-100%.	OUTCOME 1. Re-rate belief in automatic thought(s), 0-100%. 2. Specify and rate subsequent emotions, 0-100.

EXPLANATION: When you experience a unpleasant emotion, note the situation that seemed to stimulate the emotion. (If the emotion occurred while you were thinking, daydreaming, etc., please note this.) Then note the automatic thought associated with the emotion. Record the degree to which you believe this thought: 0%=not at all; 100%=completely. In rating degree of emotion: 1=a trace; 100=the most intense possible.

counselor would suggest to the victim alternative thoughts, such as "Very few burglars are foolish enough to try to break in when someone is home", or "The new locks I've installed would make it very hard for someone to break in." These disputations are written down under the "Realistic Answers" column. The victim would take the completed chart with her when she left the session, and would be encouraged to refer to it when anxious feelings arose.

Mid-way through sample intake, a clinical psychologist, experienced in the use of cognitive resturcturing therapy, trained the VSA counselors participating in the study in the use of this technique. (Only one of the counselors had prior experience with cognitive-behavioral methods.) Training consisted of two 2-hour group sessions with the counselors, which included a description of the technique and role-playing. Following the group training sessions, the psychologist visited each counselor at their workplace to observe counselors using the technique with clients and give counselors feedback on their mastery of the method. At the completion of sample intake, a third group meeting was held with counselors at which they discussed their experience with the technique and evaluated its usefulness in counseling victims.

Counselors participating in the study were instructed to use cognitive restructuring as an additional tool for clients assigned to the cognitive group. That is, sessions for victims

in the cognitive condition still included the crisis counseling elements of venting, reassurance, marshalling resources, and so forth in addition to the completion of the cognitive situation chart. Counselors were also instructed to assess victims' material needs and provide concrete assistance in the cognitive condition, as they did in the crisis counseling condition.

Initially, the instructions given to counselors called for introducing cognitive restructuring in the first counseling session with clients. However, when counselors strongly objected that the technique was not always appropriate for use in an initial session (see Chapter 4 for details), protocol was changed somewhat. Counselors were still urged to use the technique during the first session, but were permitted to delay its introduction until the second session if they felt earlier use would be detrimental. Unfortunately, one consequence of this change was that some victims assigned to the cognitive group never underwent cognitive restructuring when its use was postponed and the victim did not return for a second session of counseling (see the section of this chapter on Procedures for a further discussion).

Each counselor participating in the study was asked (with the clients' permission) to tape record two counseling sessions in which they used cognitive restructuring. The tapes were used to assess counselors' mastery of the method, and exerpts are used in

Chapter 5 which discusses counselors' experiences with cognitive restructuring.

3. Material Assistance Only

Victims sampled into this condition were assessed for material needs as in the previous two conditions. The assessment was done, however, by the research interviewer who administered the initial psychological assessment battery, rather than by a VSA counselor. To prepare for this role, interviewers spent several days prior to the start of intake working with counselors participating in the study to learn about assessing victims' material needs, about the types of assistance available, about making eligibility determinations, and about procedures for applying for or giving assistance. Victims in this condition did not receive counseling.

Material assistance provided included emergency assistance (cash, food coupons, shelter); security services (lock repair and security surveys); document replacement; assistance in filing claims with the state compensation board; and referral, information, and advocacy for an array of social service organizations (courts, police, welfare, social security, housing, legal assistance, employment counseling, mental health agencies, tenants' groups, and so forth).

4. No Service Control

Victims sampled into the no-service control recieved neither counseling nor material assistance. As was true for victims in the previous conditions, they did participate in two sessions conducted by a research interviewer to assess psychological functioning.

Because they did receive an initial psychological assessment (lasting 3/4 of an hour or more) which may in itself have had some therapeutic value, the control group is not a true no-treatment group. It was recognized that a post-test only condition (i.e., in which victims would have rceived a follow-up interview only) would have been desireable to determine if there was therapeutic value in receiving an initial psychological assessment; however, funds did not permit post-hoc inclusion of such a group. Moreover, given the limited evidence for assessment effects even in studies with repeated, lengthy assessments (see, for example Kilpatrick, 1984; Atkeson, et. al. 1982; Resick, et. al. 1981; and Calhoun, et. al. 1982), it seems unlikely that the single, relatively brief assessment used in the present study would have had significant therapeutic value.

D. Measures of Psychological Functioning

1. Standardized Measures

One of the goals in selecting measures for the study was that they be standardized tests that had known psychometric properties. This was stipulated so that results of the study could be compared to results obtained by other victim researchers. Another criteria for selection of measures was that they had been shown by other researchers (a) to distinguish victims from non-victims, and (b) to detect positive changes over time as victims recovered from the effects of crime. Most importantly, the scales chosen had to be ones which world be sensitive to improvements in victims' psychological states due to brief counseling interventions.

Based on these criteria, an initial list of standardized scales was drawn up. The list included Derogatis' Symptom Checklist 90-R (SCL-90R), Horowitz's Impact of Event Scale (IES), Derogatis' Affect Balance Scale (ABS), the Beck Depression Inventory (BDI), and the Spielberger State-Trait Anxiety Index (STAI). In order to reduce redundancy and to keep the amount of time needed for the assessment to a reasonable level (about one hour), the BDI and STAI were eventually dropped from the battery.

For all psychological scales used, results were only used in the data analysis if at least 80% of scale items were completed by the victim.

Descriptions of the standardized measures finally adopted include:

° Impact of Event Scale (Horowitz, Wilner, and Alvarez, 1979)

The IES is a 15-item scale developed to measure two aspects of post-traumatic stress disorder: (a) intrusive ideas, images, feelings, or bad dreams, and (b) avoidance of ideas, feelings, or situations connected to the stressful event. It has high internal consistency (alpha = .78 for the Intrusion subscale and alpha = .82 for the Avoidance Subscale) and high test-restest reliability (.89 for Intrusion; .79 for Avoidance). Significant changes in IES scores were found over 18 months following rape by Kilpatrick and Veronen (1983).

° Symptom Checklist-90R (Derogatis, Rickels, and Rock, 1976)

The SCL-90R is a 90-item inventory designed to measure a range of stress symptoms. Its subscales include Somatization, Obsessive-Compulsiveness, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid, Ideation, and Psychoticism. It has high internal consistency (alpha = .95) and test-retest reliability (.81). Kilpatrick, Veronen, and Resick (1979) found significant declines on four SCL-90R subscales in the six months following rape. They also found that the SCL-90R successfully distinguished victims from matched non-victim controls.

° Affect Balance Scale (Derogatis, 1975)

The ABS is a 40-item adjective checklist that measures both positive and negative affect. Its four positive subscales include Joy, Vigor, Affection, and while its negative subscales include anxiety, depression, hostility, and guilt. Seven of the eight ABS subscales were shown by Friedman, et. al. (1982) to register significant changes in the expected directions for a sample of a robbery, assault, and burglary victims over the months following victimization.

2. Created Indices

In addition to these three standardized scales, the initial assessment batttery also included two indices constructed specifi-

cally for the study. Both were designed to reflect changes in adjustment expected to occur through counseling. The first was an index of fear of crime, based on a scale used in an earlier VSA study by Friedman, et. al. (1982). In that study, the scale proved sensitive to changes in victims' adjustment over the first four months after the crime. Items included:

- Fear of certain places or situations
- Fear of certain types of people
- Fear of nervousness in one's home
- Fear of nervousness in one's neighborhood
- Fear of going out along at night
- Fear of going out along during the day

The second created index measured behavioral adjustment, and was based partly on a scale employed by Smith and Cook (1985). Items included in the index were:

- Job performance
- Relating to spouse
- Accomplishing daily chores
- Keeping appointments
- Parenting
- Making decisions
- Relating to people at work
- Solving problems

3. Measures of Victim Perceptions

Another set of measures included in the study aimed to assess how victims appraised their experience. As discusssed in the first chapter, it appears that how people view a traumatic event affects their psychological and physical health in the following months and years. Moreover, cognitive restructuring, which is

intended to alter the way that people view situations might be expected to result in changes in measures of respondents' perceptions of their victimization.

Measures of victims' perceptions included:

a. Measures of self blame

- ° Do you feel responsible for what happened?
- ° Is there anything you could have done differently to have prevented the crime from happening?

b. Measures of "selective evaluation" (Taylor, et. al., 1983)

- ° What happened to me really wasn't that bad compared to what some victims go through.
- ° Since your experience as a crime victim, do you feel any better able to handle yourself well in a crisis?
- ° In a way, I was lucky things didn't turn out worse for me than they did.
- ° Are there any positive things you can think of that resulted from your experience?
- ° Under the circumstances, I think I'm handling things pretty well.

c. Measures of Control

- ° Since the crime do you feel less control over your life?
- ° How likely is it that you will be a crime victim in the next year?

4. Other Measures

The initial assesment battery also included questions about victim demography, the crime, and precautions taken to guard against re-victimization.

The follow-up assessment battery was virtually identical to the initial battery, except that questions were added about services and social support received by the victim. Copies of both initial and follow-up assessments are contained in Appendix A.

E. Procedures

The sample was drawn from felony crime complaints in eight New York City precincts: In Manhattan, the 6th, 9th, 23rd, and 25th precincts; in the Bronx, the 40th and 44th precincts; and in Queens, the 110th and 112th precincts. All victims 17 years and older reporting complaints of robbery, burglary, felonious assault, and rape during the study's intake period were considered candidates for the study, with the exception of domestic violence cases.[2] Table 2.1 presents a breakdown of the numbers of potentially eligible victims in each participating precinct during the study's intake phase, which ran from 7/7/84 to 3/8/85.

Twice each week letters were mailed to victims who had filed complaints in one of the eligible felony categories, soliciting their participation in the study. The letter encouraged those victims who were interested in participating in a research project to contact their local precincts to arrange for an interview. In order to obtain a sample of victims comparable to those receiving services in precincts served by VSA, the letter

TABLE 2.1: MONTHLY FELONY COMPLAINTS IN PRECINCTS FROM WHICH STUDY VICTIMS WERE DRAWN

	Rape	Robbery	Assault	Burglary
6th Precinct	1	73	18	115
9th Precinct	4	78	35	111
13th Precinct	3	88	21	184
17th Precinct	2	47	8	114
40th Precinct	6	149	59	124
44th Precinct	11	139	77	210
110th Precinct	4	68	24	133
112th Precinct	1	39	10	107

requested that only those victims experiencing problems stemming from the crime participate in the study. The letter further informed victims that they would receive $5 for the initial interview and $15 for a follow-up interview three months later. After one week had passed, attempts were made to contact by phone victims who had not yet responded to the letter.

In order to secure access to felony complaints in the designated precincts, permission of the New York Police Department had to be secured. The NYPD initially insisted that its own staff send the outreach letters and make the follow-up calls in order to preserve the privacy of victims. Therefore, from 7/7/84 through 10/31/84 letters and calls were made by Crime Prevention Officers (CPOs) in each participating precinct. The names and phone numbers of victims who agreed to participate were then given to staff of the research project. In October, 1984 the NYPD reversed its position and allowed staff of the research project to send letters and make calls.

All together, approximately 4950 letters were sent to victims in the eligible crime categories. Phone contact was made with about 1900 victims, and 421 agreed to schedule interview appointments.[3] Two hundred-eighty five kept the appointments and were interviewed, about 15% of those successfully contacted by phone. While this is a low proportion, it should be kept in mind that both letters and phone conversations soliciting participation

stressed that the study was seeking only victims who were experiencing crime-related problems.

All victims who came for their initial appointments met with a staff member of the research project at the VSA neighborhood office nearest the precinct in which they resided. The research staff member administered the assessment battery. After the assessment (typically 3/4-1½ hours), control group victims were excused; victims in the Material Assistance Only group were assessed for service needs by the interviewer and the interviewer provided services as needed; and victims in the two counseling groups were sent on to see a VSA counselor for material assistance assessment and psychological counseling.

Assignment of victims to treatments was accomplished by means of a centralized random assignment sheet. The sheet consisted of consecutively numbered rows, each now associated with a group designation using a table of random numbers. When a research staff member at one of the sites set up an interview appointment with a victim, the staff member called a central phone number and gave the name of the victim. The victims' name was recorded in the next available row on the assignment sheet, and the interviewer was told the victim's assignment number and group designation.[4]

Of the 285 victims receiving an initial interview, 13 were eliminated because they appeared psychotic, had been previously

institutionalized, resided in a group home for the emotionally disturbed, or were under age 17. An additional 23 victims were dropped from the study because they had been assigned to one of the counseling treatment but refused to see a counselor or a counselor was unavailable to see them upon completion of the assessment battery.

Of the 249 remaining victims, 72 were assigned to the Control group, 68 to the Material Assistance Only group, 61 to the Crisis Counseling group, and 48 to the Cognitive Restructuring group. However, 14 of the 48 victims assigned to the Cognitive Restructuring group failed to actually receive cognitive restructuring in their counseling session. (This was easy to assess because the cognitive technique involved filling out of the Situation Chart, a copy of which was included in the victim's file.) The reason the 14 victims failed to receive cognitive restructuring was because counselors felt that, in those cases, introducing the method in the first counseling session would have been detrimental to the victim (see section C of this chapter and chapter 5 for details). Unfortunately, these victims did not return for a second session. These 14 victims did, though, receive the crisis counseling and material assistance components of their counseling sessions, and therefore have been included in the Crisis Counseling group. We recognize that this decision clouds comparisons between the Crisis Counseling and Cognitive

Restructuring treatments (because the reassignment of the 14 victims was not random). However, we are interested foremost in overall differences between victims counseled by any method and control victims. The analysis plan was that, if gross differences were found between victims counseled and those not counseled, the 14 reassigned victims would be deleted in comparing the Crisis Counseling to the Cognitive Restructuring conditions. Thus, the final cell sizes are 72 Control victims, 68 Material Assistance Only victims, 75 Crisis Counseling victims, and 34 Cognitive Restructuring victims.

Victims were contacted again for a follow-up interview conducted three months after initial assessment. One hundred eighty eight, or 76% of the sample of 249, completed the second interview.

To ascertain whether the sample of victims participating in the research study was comparable in terms of psychological adjustment to victims who seek services from VSA, the initial assessment battery was administered to a small sample (n=16) of regular clients of the three VSA neighborhood offices participating in the study. This sample included victims of robbery, assault, and burglary who sought services from VSA, and who were recruited through advertisments posted at the participating offices between December, 1984 and March, 1985.

F. Strengths and Weaknesses of the Research Method

VandenBos and Pino (1980) reviewed research on the outcomes of psychotherapy and found much of it methodologically lacking. They proposed several guidelines for studies to ensure that results are meaningful. The research method for the present study, as finally adapted, attempted to satisfy VandenBos and Pino's criteria:

(1) Studies should include a well-defined target population so that the research can generate a clear statement about the circumstances under which the treatment studied is likely to be successful.

The present study included as participants people who had been subjected to a single, discrete stressor (felony crime). It excluded victims of domestic violence, often a recurring, rather than discrete, situation.

(2) Outcome measures should be chosen to reflect specific changes that the treatment is expected to produce.

Both counseling treatments employed in the study are intended to alleviate intrusive thoughts and avoidance of crime-related cue (measured by the Impact of Event Scale); and anxiety and phobic fears (measured by Symptom Checklist-90R).

(3) The treatment should be well-defined, and efforts should be made to ensure consistency of treatment methods from therapist to therapist.

The cognitive treatment in the present study meets the

criterion of being well-defined, since it involved use by the therapist of a specific form, filled out in interaction with the client. Crisis counseling, however, was not so well-defined. To ensure uniformity between therapists, tape recordings of two counseling sessions were obtained from each participating counselor.

(4) The research should employ an appropriate control group--ideally one obtained through random assignment. The design as finally adapted randomly assigned participants to treatments.

Because of the use of random assignment, the four groups of participants were highly comparable prior to treatment. Table 2.2 shows that there were no significant pre-treatment differences between groups in terms of type of crime, or measures of victim demography.

But, while the random assignment aspect of the revised research design did add considerable strength to the study methodology, the revised design did raise a new concern. Study participants were recruited from victims filing complaints with the police in precincts adjacent to, but not served by, VSA offices, rather than from among persons seeking VSA services. (This was to avoid the ethical problem of denying services to VSA clients.) Therefore, the possibility existed that victims who

TABLE 2.2: DIFFERENCES BETWEEN GROUPS IN VICTIM AND CRIME CHARACTERISTICS PRIOR TO TREATMENT

Crime Type	Control (n=72)	Concrete Services (n=68)	Crisis Counseling (n=75)	Cognitive Restructuring (n=34)	Significance[1] (Chi-squared)
Burglary	37%	44%	39%	38%	
Robbery	31%	33%	32%	47%	
Assault	31%	20%	27%	13%	
Rape	1%	3%	3%	3%	
	100%	100%	100%	100%	7.49
Victim Injured?					
Yes	34%	32%	35%	22%	
No	66%	68%	65%	78%	2.11
	100%	100%	100%	100%	
Life Threatened During Crime					
Yes	58%	62%	51%	46%	2.66
No	42%	38%	49%	54%	
	100%	100%	100%	100%	
Sex					
Male	59%	50%	48%	53%	
Female	41%	50%	52%	47%	
	100%	100%	100%	100%	2.54
Live Alone					
Yes	41%	35%	45%	25%	
No	59%	65%	55%	75%	
	100%	100%	100%	100%	4.67
Age					
0-29	30%	25%	23%	31%	
30-59	52%	60%	57%	59%	
60+	18%	15%	19%	9%	
	100%	100%	100%	100%	2.90
Education					
Non H.S. Grad	24%	16%	27%	28%	
H.S. Grad	45%	52%	47%	65%	
College Grad+	31%	32%	27%	6%	
	100%	100%	100%	100%	9.89
Household Income					
0-9,999	42%	39%	37%	60%	
10,000-19,999	32%	25%	40%	20%	
20,000+	26%	36%	23%	20%	
	100%	100%	100%	100%	8.38
Source of Income					
Job	58%	57%	49%	53%	1.49
Other	42%	43%	51%	47%	
	100%	100%	100%	100%	
Ethnicity					
Black	34%	38%	42%	53%	
Hispanic	19%	15%	15%	22%	
White	43%	42%	41%	22%	
Other	4%	5%	1%	3%	
	100%	100%	100%	100%	7.46
Treated for Emotional Problems in Year Before Crime					
Yes	21%	12%	11%	19%	
No	79%	88%	89%	81%	
	100%	[illegible]	100%	100%	3.94
Prior Victimizations					
Yes	61%	71%	62%	53%	
No	39%	29%	38%	47%	
	100%	100%	100%	100%	5.87

1. No differences significant at .05 level or better.

were not experiencing problems stemming from the crime and who would not have presented themselves for VSA services (had services been available in their precinct) might be drawn into the study. This concern was heightened by the fact that victims were offered a small incentive ($5 for the initial interview and $15 for the second) to participate. To try to reduce the number of "non-needy" participants, both mail and telephone recruitment efforts encouraged only victims experiencing crime-related problems to participate.

In spite of the screening effort, Table 2.3 shows that the means for the research sample differed significantly from means for the small sample of 16 VSA clients recruited through advertisements on the SCL-90R Global Symptom Index (a summary measure of overall symptomatology); on the total positive affect measure of the ABS; and on both Intrusion and Avoidance subscales of the IES. But these differences, while statistically significant, are not large; and no differences were detected between the research sample and VSA clients on the total negative affect measure of the ABS nor on the overall Affect Balance Index. Moreover, since the estimate of population means for VSA clients was based on only 16 cases, it may be quite inaccurate. Nonetheless, the best information at hand suggests that the research sample as a whole exhibited less severe symptomology than persons who normally seek services from VSA. Because of this, the comparisons between

TABLE 2.3: DIFFERENCES BETWEEN STUDY RESPONDENTS AND A SAMPLE OF VSA CLIENTS

	Research Sample Mean	VSA Client Mean[1]	t
SCL-90R			
Global Symptom Index	0.77 (1.25)[3]	0.94	-3.78[2]
ABS			
Positive affect total	2.09 (2.08)	1.74	5.88[2]
Negative affect total	1.44 (1.91)	1.37	1.43
Affect Balance Index	0.65 (0.17)	0.73	0.94
IES			
Intrusion	2.35 (2.88)	2.67	-3.49[2]
Avoidance	2.15 (2.64)	2.36	-2.57

1. Based on a sample of 16

2. Difference between entire research sample mean and VSA client mean significant at .01 level

3. Means in parentheses are based on the half of the sample with the most severe symptomatology on the Global Symptom Index of the SCL-90R.

treatment groups reported in later chapters were conducted both for the entire sample and the half of the sample who had the highest scores on the SCL-90R Global Symptom Index. As can be seen in Table 2.3, means from this half of the research sample indicated as severe, or more severe, adjustment problems than regular VSA clients.

Another potential methodological problem was posed by the fact that about one-quarter of the victims who completed the initial interview failed to complete the follow-up interview. Analyses were run to determine whether victims who dropped out of the study prior to completing both interviews differed from those who saw the study through.

The results, presented in Table 2.4, show that there were no differences between the two groups of repondents on measures of psychological functioning. Some differences did arise, however, on measures of victim characteristics. Those who completed both interviews were significantly less likely to be male, less likely to live alone and less likely to believe that their life was in danger during commission of the crime than victims who did not complete the follow-up interview. To a degree, these differences limit the generalizability of findings presented later in this report.

TABLE 2.4(a): DIFFERENCES IN VICTIM AND CRIME CHARACTERISTICS BETWEEN RESPONDENTS WHO DID VERSUS DID NOT COMPLETE THE FOLLOW-UP INTERVIEW

	Completed Initial & Follow-up Interviews (n=181)	Completed Initial Interview Only (n=66)	Significance
Crime Type			
Burglary	41%	33%	$x^2=4.28$
Robbery	35	32	
Assault	21	33	
Rape	3	2	
	100%	100%	
Victim Injured?			
Yes	30%	41%	$x^2=2.50$
No	70	59	
	100%	100%	
Life in Danger During Crime?			
Yes	50%	68%	$x^2=5.48^*$
No	50%	32	
	100%	100%	
Sex			
Male	48%	65%	$x^2=6.03^*$
Female	52	35	
	100%	100%	
Live Alone			
Yes	34%	50%	$x^2=5.45^*$
No	66	50	
	100%	100%	
Age			
0-29	24%	31%	$x^2=2.86$
30-59	61	48	
60+	15	20	
	100%	100%	
Education			
Non H.S. Grad	21%	31%	$x^2=3.37$
H.S. Grad	53	42	
College Grad	27	27	
	100%	100%	
Household Income			
0-9,999	43%	40%	$x^2=0.31$
10,000-19,999	32	31	
20,000+	25	29	
	100%	100%	
Main Income Source			
Employment	56%	51%	$x^2=0.52$
Other	44	49	
	100%	100%	
Ethnicity			
Black	43%	33%	$x^2=2.28$
Hispanic	16	20	
White	38	42	
Other	3	5	
	100%	100%	
Treated for Emotional Problems in Year Before Crime			
Yes	15%	14%	$x^2=0.13$
No	85	86	
	100%	100%	
Prior Victim?			
Yes	64%	62%	$x^2=0.13$
No	36	38	
	100%	100%	

* Significant at .05 level
** Significant at .01 level

TABLE 2.4(b): DIFFERENCES ON SCALES AND CONSTRUCTED INDICES BETWEEN RESPONDENTS WHO DID VERSUS DID NOT COMPLETE THE FOLLOW-UP INTERVIEW

	Completed Initial & Follow-Up Interviews (n=181)	Completed Initial Interview Only (n=66)	Significance
SCL-90R			
Somatization	0.89	0.94	F(1,227)=0.20
Obsessive-Compulsive	0.78	0.73	F(1,227)=0.26
Interpersonal Sensitivity	1.03	1.09	F(1,227)=0.21
Depression	0.86	0.78	F(1,227)=0.46
Anxiety	0.66	0.70	F(1,227)=0.16
Hostility	0.77	0.83	F(1,227)=0.26
Phobic Anxiety	0.74	0.69	F(1,227)=0.26
Paranoid Ideation	0.63	0.60	F(1,227)=0.08
Psychoticism	0.74	0.69	F(1,227)=0.20
Global Symptom Index	0.78	0.77	F(1,227)=0.01
Affect Balance Scale			
Joy	1.99	1.96	F(1,226)=0.03
Contentment	1.98	1.93	F(1,226)=0.12
Vigor	2.06	2.00	F(1,226)=0.22
Affection	2.38	2.32	F(1,226)=0.16
Anxiety	1.76	1.63	F(1,226)=1.03
Depression	1.38	1.21	F(1,226)=1.68
Guilt	1.10	1.02	F(1,226)=0.48
Hosility	1.68	1.49	F(1,226)=1.79
Overall Negative	1.48	1.34	F(1,226)=1.72
Overall Positive	2.10	2.05	F(1,226)=0.13
Affect Balance Index	0.62	0.72	F(1,226)=0.26
Impact of Event Scale			
Avoidance	2.15	2.18	F(1,235)=0.04
Intrusion	2.36	2.34	F(1,235)=0.00
Overall	2.24	2.25	F(1,235)=0.00
Constructed Indices			
Adjustment difficulties	2.09	5.20	F(1,244)=1.03
Fear	2.52	5.02	F(1,244)=0.19

*Significant at 05. level
**Significant at 01. level

Chapter II Footnotes

1. Based on a sample of 10 cases each of burglary, robbery, domestic violence, and rape taken from the files of each neighborhood office in March, 1984.

2. Domestic violence cases were excluded on recommendation of the Advisory Committee because the "crisis" in such cases is typically not a discrete event.

3. Because Police Department records pertaining to intake for this study were lost, we do not know the exact number of letters sent or victims contacted by phone. The numbers reports in the text were reconstructed from partial records available to the project. No information at all was available on phone calls attempted, although it is certain that not all victims who were sent letters were called as the study methodology called for.

4. The assignment sheet was set up such that all crisis counseling assignments occurred during the first half of the study (i.e., the first 120 victims), while all cognitive restructuring assignments occurred during the second half of the study. Since intake extended beyond the initial target of 240 victims, more victims wound up in the Cognitive Restructuring group than the Crisis Counseling groups.

III. RESULTS OF THE EXPERIMENT

This section, looks at the victims and the crimes that make up the sample, and discusses what was done for victims who were assigned to the Crisis Counseling, Cognitive Restructuring, and Material Assistance Only treatments. With that background, the chapter next examines in detail the effects of these treatments on victims' psychological and material adjustment in the months following the crime.

A. About the Sample

There was little remarkable about the sample in terms of demography. By most measures, it appeared to represent a good cross-section of victims. Men and women were represented in equal numbers as were Blacks and Whites, with lesser proportions of Hispanic and respondents of other races (see Table 3.1). A majority was in the 30-59 age group, and two in three lived with one or more other persons.

It had been anticipated--based on VSA's clientele and the fact that a monetary incentive was offered to research participants--that most victims who agreed to take part in the study would be from the lower end of the socioeconomic spectrum. That expectation proved basically true. Four in ten respondents reported household incomes of less than $10,000 per year and less

TABLE 3.1: SAMPLE DEMOGRAPHY

Sex	
Male	52%
Female	48
Ethnicity	
Black	41%
White	39
Hispanic	17
Other	3
Age	
0-29	26%
3-59	57
60+	16
Live Alone?	
Yes	38%
No	62
Household Income	
0-9999	42%
10-19,999	31
20,000+	26
Principal Source of Income	
Job	55%
Other	45%
Education	
Not H.S. grad.	23%
H.S. grad.	50
College grad.	27
Prior Victim?	
Yes	63%
No	37
Treatment for Emotional Problems Last Year?	
Yes	15%
No	85

than six in ten reported that the principal source of their income was their job or their spouse's job. On the other hand, however, three in four respondents had graduated from high school and one in four earned in excess of $25,000 per year.

There was good representation of burglaries (39%), robberies (34%), and assaults (24%) in the sample, as well as a small number of rapes (2%). Most victimizations--including two-thirds of the crimes other than burglary--occurred in respondents' neighborhoods. Fifty-five percent believed that their lives had been in danger during the crime.

Most victims suffered some tangible consequences as a result of the crime. One in three were injured. Three in four had property stolen. One in three had property damaged. And one in five lost some time from work due to the crime.

It is unfortunate that the questionnaire did not include a measure of recent (pre-crime) life stress. We do know from our statistical results that two-thirds of the sample reported being victimized on previous occasions, and that 15% had sought treatment for a mental or emotional problem within the past year. But these data do not begin to capture the myriad of pre-crime stressors that emerged for a number of victims whose counseling sessions were taped. For example, one woman--the victim of an assault by an acquaintance--had suffered an almost unbelieveable

number of hardships. She had borne five children, three of whom had died. She had lost custody of the remaining two to her husband, even though he had beaten her when they lived together. Three of her siblings had died, and her only remaining brother was paralyzed. Her grandmother had died recently, and the respondent was involved in providing support for her mother, who had taken the death very hard. At the time of the counseling session, she was also out of work and having problems with her landlord. On top of everything else, doctors had informed her at the emergency room where she was treated after the assault that she might have cancer and ought to return for tests.

Another woman who worked for the transit authority had been the victim of a mugging by two men in the elevator of her apartment building. During the session it came out that she had been mugged in similar fashion twice before and, in one case, stabbed. Later in the session she also revealed that she had been the victim of two rapes--one when she was 14--that she had never told anyone about before. She had also attempted on several occasions to commit suicide.

Thus, for at least a portion of respondents, the crime sampled for the study probably did not constitute a singular crisis in their lives. Rather, it was just one event in a pattern of debilitating events and circumstances that constitute the lives of inner city residents.

B. Measuring Treatment Effects on Victims' Material Adjustment

In the interview prior to treatment, victims were asked about financial, medical, job-related, and other problems they were experiencing as a result of the crime. The most common category of problem, reported by 48% of the sample, was "other". A check of the responses of individual victims showed that, with only six exceptions, these "other" problems were emotional--manifestations of nervousness, vulnerability, or depression brought on by the crime. For example, a waitress who was a victim of an attempted rape at knifepoint outside of her apartment related:

> I don't leave my apartment at night, except when I have to go to class, and then I always have someone with me. I can't look a Black or Spanish man in the eye. I'm very angry.

Frequently, post-crime stress aggravated medical conditions, as in the case of a 65-year old nurse's aid who lost appliances, clothes, jewelry, and cash when her apartment was broken into:

> I'm really disturbed worrying over what happened. I'm always thinking about it. My heart problem acted up and I went to the hospital [shortly after] the robbery.

Nearly half of the sample (43%) reported having problems "making ends meet" as a result of victimization. While seemingly high, this proportion is not surprising given what we have noted about the low incomes of much of the sample. The economic impact

of crime was felt most strongly by victims on public assistance, including a woman who lost $2500 worth of household goods and was nearly raped when she surprised two burglars:

> I couldn't afford to even by a 5¢ candy bar. They took my meat, my son's clothing--almost everything from me.

Seventeen percent of the sample reported medical problems (other than those due to stress) arising from the crime. These consisted of victims who were suffering pain or whose physical abilities were hampered by injuries, as in the case of a "good Samaritan" who could not use one hand after being beaten by several youths when he came to the rescue of a woman being robbed.

Finally, 17% of the sample reported that the crime had affected their ability to work for a variety of reasons, including injury or stress-related problems. Other victims lost tools necessary to their trade, such as a victim who moonlighted as a photographer, but who lost his equipment when his residence was burglarized.

Victims in three of the treatment groups were assessed for material assistance needs by a research interviewer (Material Assistance Only group) or counselor (Crisis Counseling and Cognitive Restructuring groups). Those victims found to be in need were then given material aid to assist them with problems

they were experiencing as a result of the crime. For example, victims having trouble making ends meet might be given small amounts of cash for groceries, a referral to welfare emergency assistance for larger cash grants, or assistance in applying for crime victims compensation from the state. Victims expressing anxiety about being re-victimized might be provided with lock repair or replacement services from VSA's Project SAFE, or a referral for a free police security check.

Table 3.2, based on records of counselors and interviewers, shows that most victims in the three service groups did, in fact, receive some form of material assistance. Most common types of help provided were cash assistance, referral for free lock repair/replacement, assistance in applying for crime victim compensation, and referral to the police for a security survey.

On average, victims in the Material Assistance only group received more units of service than victims in the two counseling groups. Apparently the interviewers who dispensed services to the Material Assistance Only group used more liberal criteria in determining eligibility than are normally used by VSA counselors. This seems to have been especially true for referrals to the police for security surveys, which were often given by research interviewers but given only once by counselors.

Because of the provision of material assistance, it was expected that victims in the two counseling and in the Material

TABLE 3.2: MATERIAL ASSISTANCE PROVIDED TO VICTIMS BY TREATMENT GROUP

	Material Assistance Only (n=68)	Crisis Counseling (n=75)	Cognitive Restructuring (n=34)
Cash assistance	18	14	14
Lock repair/replacement	21	9	8
Assistance applying for victim compensation	6	8	4
Referral to police for security survey	12	1	0
Information or assistance with police or courts	5	4	0
Mental health referral	4	2	0
Referral for welfare emergency assistance	1	0	3
Document replacement	0	1	0
Assistance with property return	0	1	0
Medical referral	1	0	0
Other	11	6	3
Total units of assistance provided:	77	46	32
Average # units of assistance per victim:	1.13	0.62	0.94

Assistance Only group might report fewer crime-related problems on the follow-up interview than victims in the Control groups. Prior to examining treatment effects, however, it is necessary to ensure that no significant differences in crime-related problems existed between groups before treatment. That is done in the top half of Table 3.3. It shows that, while victims in the Cognitive Restructuring group did report somewhat more problems than victims in the other groups, their was no overall significant difference between groups prior to treatment.

The bottom half of Table 3.3 shows the post-treatment results. During the three months between first and second interviews, the rate of victims experiencing one or more problems declined dramatically from 73% to 22%. But there remains no significant difference between treatment groups: The decrease in problems was equally sharp in all groups. Thus there is no evidence that material assistance reduces the crime-related problems assessed in the study.

A check was made to determine whether it might be that victims in the Control group received help from other sources to compensate for not getting material assistance from VSA. But no differences were apparent between treatment groups in assistance from other professional sources or in assistance from family, friends or acquaintances. Rather, the failure to find treatment effects may have been due in large part to the fact that most

TABLE 3.3: CRIME-RELATED PROBLEMS REPORTED BY VICTIMS BEFORE AND AFTER TREATMENT

	Crisis Counseling (n=53)	Cognitive Restructuring (n=26)	Material Assistance Only (n=53)	Control (n=49)
# of Problems Prior to treatment[1]				
0	26%	15%	30%	31%
1	30	35	36	39
2+	43	50	34	30
	100%	100%	100%	100%
Mean	1.32	1.54	1.13	1.10
# of Problems After treatment[2]				
0	77%	77%	74%	86%
1	19	15	19	14
2+	4	8	7	0
	100%	100%	100%	100%
Mean	0.26	0.31	0.36	0.14

[1] Chi-square with 6 degrees of freedom = 4.72 (ns)

[2] Chi-square with 6 degrees of freedom = 5.37 (ns)

crime-related problems simply do not last for three months after victimization. Moreover, the measures of material adjustment used may have been too gross to detect effects of help rendered by VSA. Twenty or thirty dollars cash for groceries cannot overcome all the financial problems of a victim whose apartment has been cleaned out, nor is a new lock likely to completely resolve the a victim's inability to sleep because he or she believes that his or her apartment is not safe any more.

C. Measuring Treatment Effects on Victims' Psychological Adjustment

A variety of measures were used to test the effects of counseling on victims' psychological adjustment. These included three standardized tests of psychological functioning as well as several series of custom questions that measured fear of crime, behavioral adjustment difficulties, and perceptions of victimization. All measures were taken both immediately prior to the provisions of services and again three months later.

In planning the study, it was assumed that victims counseled at VSA typically spent several sessions with a counselor. However, as mentioned in the previous chapter, that assumption was proven false in the planning phase of the present research. By taking a small sample of rape, robbery, burglary, and assault cases from several of VSA's community offices it was discovered

that, except for rape victims, the average number of counseling sessions per client was well under two. That was a worrisome finding because crisis counseling or cognitive restructuring would have to be very effective, indeed, to affect victims' psychological states significantly in only one to two sessions. For a time there was discussion of limiting the study to rape victims or other clients who tend to return for several counseling sessions. But in the end that idea was discarded because the aim of the research was to study crisis counseling as it actually is used by victim programs--and that includes its use with victims of burglary, robbery, assault, and other crimes who may be counseled for only one or two sessions.

In the present study, the great majority of victims who received either crisis or cognitive counseling saw a counselor for only one session. Among victims receiving crisis counseling 91% came for one session and 9% for two or more sessions. Among victims receiving cognitive restructuring, 18% returned for additional sessions.[1] While victims in the study were not remarkably different from actual VSA clients in terms of the number of counseling sessions attended, it should be kept in mind that trying to isolate effects of such "weak" treatments is a difficult business at best.[2]

1. Standardized Measures of Psychological Functioning

As described in the previous chapter, three widely-used measures of psychological functioning were used in the study. The Impact of Event Scale (IES), a measure of post-traumatic stress disorder, includes subscales for Intrusion (extent to which the respondent is obsessed by thoughts or dreams relating to a traumatic event) and Aviodance (extent to which the respondent avoids cues associated with the traumatic incident). The Affect Balance Scale (ABS), a measure of the relative dominance of positive versus negative moods, includes positive subscales for Affection, Vigor, Contentment, and Joy and negative subscales representing Depression, Hostility, Anxiety, and Guilt. The Symptom Checklist 90-R (SCL-90R) is a measure of general psychopathology, which includes subscales measuring Somatization, Obsessive-Compulsiveness, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism.

In order to be useful for the study, there are two criteria that measures ought to meet. First, they must be sensitive to the effects of victimization. That is, victims ought to score higher on the tests shortly after victimization than non-victims. Second, the tests ought to be sensitive to readjustment process that victims undergo. In other words, they must show improved psychological functioning over the months following victimization.

To determine if the tests were sensitive to the effects of victimization, it would have been desireable to compare the victim sample to a control sample of non-victims drawn from the same neighborhoods. However, drawing a control sample of non-victims was well beyond the limited financial scope of the study. What was done instead was to compare the victim sample to published norms for the tests, keeping in mind that the norms probably underrepresent pre-victimization psychopathology in an inner-city sample. In Table 3.4, pre-treatment scores from the victim sample are compared to published norms for the IES, ABS, and SCL-90R. On every subscale of the three tests, scores from the victim sample differed significantly from test norms. We cautiously conclude, therefore, that the tests do distinguish victims from non-victims.

Table 3.5 examines the question of whether the psychological scales used are sensitive to respondents' readjustment in the months following victimization. The table shows that the overall measures for all three tests did change significantly in the expected directions. That is, post-traumatic stress disorder as measured by the Impact of Event Scale overall score declined; psychopathology as measured by the Global Symptom Index of the SCL-90R declined; and mood states as measured by the Affect Balance Index (positive affect as a proportion of overall effect) improved. Both subscales of the Impact of Event Scale (Intrusion

TABLE 3.4: PSYCHOLOGICAL TEST NORMS COMPARED TO VICTIM SCORES SHORTLY AFTER VICTIMIZATION

	Test Norm	Victim Sample Mean (n=247)	Victim Sample Standard Deviation	Significance (t)
Symptom Checklist 90-R				
Somatization	0.36	0.90	0.67	12.17[1]
Obsessive-compulsive	0.39	0.77	0.67	8.56
Interpersonal sensitivity	0.29	1.04	0.88	12.87
Depression	0.36	0.84	0.79	9.17
Anxiety	0.30	0.67	0.67	8.33
Hostility	0.30	0.79	0.76	9.74
Phobic Anxiety	0.13	0.73	0.74	12.24
Paranoid Ideation	0.34	0.62	0.73	5.79
Psychoticism	0.14	0.72	0.80	10.95
Global Symptom Index	0.31	0.77	0.64	10.85
Affect Balance Scale[2]				
Anxiety	1.42	1.73	0.86	5.43
Depression	0.93	1.33	0.87	6.93
Guilt	0.77	1.08	0.81	5.77
Hostility	1.06	1.63	0.92	9.34
Joy	2.59	1.98	1.02	-9.01
Contentment	2.61	1.97	0.99	-9.74
Vigor	2.73	2.05	0.95	-10.79
Affection	2.84	2.37	1.00	-7.08
Positive mean	2.68	2.09	0.90	-9.88
Negative mean	1.06	1.44	0.74	7.74
Affect Balance Index	1.59	0.65	1.26	-11.24
Impact of Event Scale[2]				
Intrusion	0.60	2.35	1.41	19.06
Avoidance	0.68	2.16	1.23	18.48
Overall	0.64	2.25	1.16	21.32

[1]All t values significant at .01 level by one-tailed test.

[2]Test norms weighted to relfect proportion of males and females in victim sample.

TABLE 3.5: COMPARISON OF VICTIMS' PSYCHOLOGICAL TEST SCORES SHORTLY AFTER VICTIMIZATION AND 3 MONTHS AFTER VICTIMIZATION

	Victim Sample Mean Shortly After Crime [1] (n=181)	Victim Sample Mean 3 months After Crime (n=181)	Significance (t)
Symptom Checklist 90-R			
Somatization	0.94	0.83	2.24 [2]
Obsessive-compulsive	0.82	0.73	2.17 [2]
Interpersonal sensitivity	1.08	0.91	3.07 [2]
Depression	0.90	0.76	2.74 [2]
Anxiety	0.71	0.70	0.12
Hostility	0.79	0.72	1.22
Phobic Anxiety	0.76	0.70	1.22
Paranoid Ideation	0.64	0.67	-0.60
Psychoticism	0.78	0.66	2.33 [2]
Global Symptom Index	0.82	0.73	2.17 [2]
Affect Balance Scale			
Anxiety	1.75	1.68	1.27
Depression	1.36	1.26	1.54
Guilt	1.10	1.02	1.42
Hostility	1.68	1.45	3.41 [2]
Joy	1.98	2.15	-2.22 [2]
Contentment	1.99	2.16	-2.26 [2]
Vigor	2.08	2.23	-2.01 [2]
Affection	2.41	2.49	-1.00
Positive mean	2.12	2.26	-2.14 [2]
Negative mean	1.47	1.35	2.58 [2]
Affect Balance Index	0.64	0.91	-3.30 [2]
Impact of Event Scale			
Intrusion	2.37	1.79	6.06 [2]
Avoidance	2.15	1.98	1.83 [2]
Overall	2.25	1.89	4.38 [2]

[1] Means differ slightly from means in Table 3.4 because they are based only on victims who completed both waves of interviews.

[2] Significant at .05 level or better by one-tailed test.

and Avoidance) and the two major subscales of the Affect Balance Scale (the Positive and Negative Affect means) also showed significant changes. So it appears that the scales did reflect changes in adjustment during the months following victimization.

The last thing we need to make sure of prior to examining the effects of counseling on victims' psychological adjustment is that no differences existed between the Crisis Counseling, Cognitive Restructuring, Material Assistance Only, and the Control groups prior to treatment. This issue is examined in Table 3.6. It shows that differences between groups prior to treatment did not approach statistical significance on any of the overall or subscale scores. Thus we are assured that the groups were functioning psychologically at roughly equivalent levels prior to beginning counseling.

If the services received by study participants were effective, we would expect that, relative to victims in the Control group, victims who received Crisis Counseling or Cognitive Restructuring would exhibit (a) fewer symptoms of post-traumatic stress disorder on the IES; (b) lower scores on the pathology measures of the SCL-90R; and (c) lesser negative and greater positive affect on the ABS. Since victims in the Material Assistance only group received concrete services but no counseling, they would be expected to score similarly to controls.

TABLE 3.6: DIFFERENCES BETWEEN GROUPS ON PSYCHOLOGICAL SCALES PRIOR TO TREATMENT

SCL-90R	Control (n=72)	Material Assistance Only (n=68)	Crisis Counseling (n=75)	Cognitive Restructuring (n=34)	Significance [1]
Somatization	0.87	0.95	0.86	0.97	F(3,224)=0.37
Obsessive-compulsive	0.70	0.81	0.75	0.89	F(3,224)=0.66
Interpersonal Sensitivity	1.03	1.06	0.98	1.19	F(3,224)=0.38
Depression	0.75	0.85	0.85	0.97	F(3,224)=0.60
Anxiety	0.62	0.68	0.69	0.68	F(3,224)=0.15
Hostility	0.74	0.76	0.86	0.80	F(3,224)=0.34
Phobic Anxiety	0.63	0.79	0.71	0.88	F(3,224)=0.97
Paranoid Ideation	0.63	0.59	0.64	0.61	F(3,224)=0.06
Psychoticsm	0.65	0.78	0.71	0.81	F(3,224)=0.42
Global Symptom Index	0.73	0.80	0.76	0.87	F(3,224)=0.36
Affect Balance Scale					
Joy	1.95	1.97	2.02	2.00	F(3,224)=0.05
Contentment	2.08	1.84	1.99	1.92	F(3,224)=0.68
Vigor	2.06	2.04	1.99	2.15	F(3,224)=0.20
Affection	2.24	2.47	2.34	2.50	F(3,224)=0.74
Anxiety	1.66	1.82	1.72	1.67	F(3,224)=0.46
Depression	1.32	1.29	1.33	1.44	F(3,224)=0.22
Guilt	1.05	1.03	1.07	1.24	F(3,224)=0.49
Hostility	1.58	1.70	1.56	1.75	F(3,224)=0.49
Overall Negative Affect	1.40	1.46	1.42	1.53	F(3,224)=0.23
Overall Positive Affect	2.08	2.08	2.08	2.14	F(3,224)=0.04
Affect Balance Index	0.68	0.61	0.66	0.61	F(3,224)=0.04
Impact of Event Scale					
Avoidance	2.11	2.18	2.12	2.28	F(3,233)=0.15
Intrusion	2.14	2.41	2.30	2.85	F(3,233)=1.86
Overall	2.12	2.29	2.20	2.53	F(3,233)=1.00

1. No tests approached statistical significance.

Table 3.7 tests these expectations about the effects of counseling on pyschological functioning. The results are clear and easy to interpret: There is no evidence that the counseling received by victims in the study had an effect on their psychological functioning as measured by the SCL-90R, the IES, and the ABS.

However, in the last chapter a question was raised as to whether victims who participated in the study were, in general, as distressed by the crime as VSA's regular clientele: That is, were study participants as in need of counseling? (Recall that study participants appeared to be functioning somewhat better on several of the psychological scales used than a sample of VSA's regular clientele.) Was it possible that Table 3.6 showed no treatment effects because treatment is only effective (i.e. only matters) for seriously distressed victims?

To test that possibility, the comparisons between treatments were run again, this time only on the half of the sample who had the most severe scores on the Global Symptom Index (overall mean) of the SCL-90R. (As we have seen in Table 2.3, psychological distress for this half of the sample as measured by the SCL-90R, the ABS, and the IES is equal to or greater than distress among the sample of VSA's regular clientele.) The comparisons of treatment effects among the most distressed half of the sample are displayed in Table 3.8. The results are virtually identical

TABLE 3.7: DIFFERENCES BETWEEN GROUPS ON PSYCHOLOGICAL SCALES AFTER TREATMENT (WHOLE SAMPLE)

SCL-90R	Control (n=48)	Material Assistance Only (n=55)	Crisis Counseling (n=53)	Cognitive Restructuring (n=25)	Significance [1]
Somatization	0.77	0.87	0.76	1.01	F(3,167)=0.68
Obsessive-compulsive	0.67	0.75	0.73	0.78	F(3,167)=0.13
Interpersonal Sensitivity	0.81	0.95	0.83	1.14	F(3,167)=0.82
Depression	0.64	0.76	0.81	0.89	F(3,167)=0.51
Anxiety	0.63	0.67	0.78	0.72	F(3,167)=0.30
Hostility	0.68	0.69	0.77	0.78	F(3,167)=0.13
Phobic Anxiety	0.57	0.70	0.82	0.74	F(3,167)=0.75
Paranoid Ideation	0.63	0.69	0.69	0.65	F(3,167)=0.05
Psychoticsm	0.61	0.63	0.73	0.65	F(3,167)=0.22
Global Symptom Index	0.66	0.73	0.75	0.81	F(3,167)=0.25
Affect Balance Scale					
Joy	2.12	2.11	2.16	2.28	F(3,164)=0.20
Contentment	2.14	2.19	2.08	2.29	F(3,164)=0.38
Vigor	2.20	2.26	2.16	2.35	F(3,164)=0.29
Affection	2.43	2.69	2.29	2.60	F(3,164)=1.92
Anxiety	1.52	1.77	1.65	1.83	F(3,164)=0.96
Depression	1.14	1.27	1.28	1.41	F(3,164)=0.56
Guilt	0.88	0.98	1.14	1.10	F(3,164)=0.80
Hostility	1.28	1.48	1.49	1.58	F(3,164)=0.73
Negative Mean	1.20	1.38	1.39	1.48	F(3,164)=0.84
Positive Mean	2.22	2.31	2.17	2.38	F(3,164)=0.49
Affect Balance Index	1.02	0.93	0.78	0.90	F(3,164)=0.31
Impact of Event Scale					
Avoidance	1.96	1.86	2.14	1.93	F(3,174)=0.38
Intrusion	1.89	1.78	1.73	1.79	F(3,174)=0.10
Overall	1.93	1.82	1.94	1.85	F(3,174)=0.10

1. No tests approached statistical significance.

TABLE 3.8: DIFFERENCES BETWEEN GROUPS ON PSYCHOLOGICAL SCALES AFTER TREATMENT (HALF OF SAMPLE WITH HIGHEST SCORES ON GLOBAL SYMPTOM INDEX OF SCL-90R)

SCL-90R	Control (n=20)	Material Assistance Only (n=25)	Crisis Counseling (n=26)	Cognitive Restructuring (n=15)	Significance[1]
Somatization	1.08	1.21	1.16	1.14	F(3,78)=0.11
Obsessive-compulsive	1.05	1.22	1.12	0.99	F(3,78)=0.29
Interpersonal Sensitivity	1.23	1.54	1.20	1.41	F(3,78)=0.75
Depression	0.95	1.24	1.21	1.17	F(3,78)=0.43
Anxiety	0.90	1.08	1.16	0.85	F(3,78)=0.58
Hostility	1.01	0.98	1.21	1.01	F(3,78)=0.29
Phobic Anxiety	0.77	1.07	1.27	0.93	F(3,78)=1.29
Paranoid Ideation	0.97	1.02	1.10	0.87	F(3,78)=0.21
Psychoticsm	0.81	0.97	1.21	0.77	F(3,78)=1.13
Global Symptom Index	0.96	1.12	1.16	1.01	F(3,78)=0.31
Affect Balance Scale					
Joy	1.88	2.08	1.92	2.13	F(3,79)=0.43
Contentment	1.91	2.20	1.85	2.13	F(3,79)=1.31
Vigor	2.17	2.18	2.18	2.30	F(3,79)=0.10
Affection	2.34	2.79	2.26	2.43	F(3,79)=1.85
Anxiety	1.99	2.08	1.98	2.06	F(3,79)=0.12
Depression	1.56	1.48	1.66	1.76	F(3,79)=0.53
Guilt	1.08	1.25	1.49	1.35	F(3,79)=0.96
Hostility	1.55	1.66	1.90	1.79	F(3,79)=0.74
Negative Mean	1.54	1.62	1.76	1.74	F(3,79)=0.50
Positive Mean	2.07	2.31	2.05	2.25	F(3,79)=0.76
Affect Balance Index	0.53	0.69	0.29	0.51	F(3,79)=0.57
Impact of Event Scale					
Avoidance	2.36	2.41	2.90	2.32	F(3,81)=1.17
Intrusion	2.43	2.55	2.42	2.18	F(3,81)=0.28
Overall	2.40	2.48	2.67	2.26	F(3,81)=0.55

1. No tests approached statistical significance.

to the whole-sample results: We are still forced to conclude that there is no evidence that the counseling received by study participants lessened psychological distress.

There is one final way in which we might try to isolate effects of counseling. That is to see whether, among those victims assigned to the two counseling conditions, those who received multiple counseling sessions showed better psychological adjustment at the follow-up assessment than victims who received a single counseling session. This analysis seemed justified by the fact that most victims received only one session of counseling, and it would be surprising, indeed, if just a single session had a demonstrable effect on adjustment.

Therefore, for victims assigned to counseling, correlations were run between the number of counseling sessions received and five summary measures from the psychological scales at the follow-up assessment. (These included the Intrusion and Avoidance scores from the Impact of Event Scale, the positive and negative affect totals from the Affect Balance Scale, and the Global Symptom Index from the Symptom Checklist 90-R.) None of the correlations were statistically significant, either with or without controlling for victims' scores from the initial assessment on the measures of adjustment.

2. Created Indices of Psychological Adjustment

In addition to the standardized tests of psychological functioning described in the previous section, two additional scales of adjustment were constructed for the study. One scale was designed to measure increases in fear of crime resulting from victimization, and the other to measure behavioral adjustment. Both of these measures reflect outcomes that counseling tries to achieve. The fear of crime measure was an expanded version of a scale used in an earlier VSA study (Friedman et. al., 1982) that had proved itself to be sensitive to the post-crime readjustment process. Items included:

- Fear of certain places or situations
- Fear of certain types of people
- Fear or nervousness in one's home
- Fear or nervousness in one's neighborhood
- Fear of going out alone at night
- Fear of going out alone during the day

Intercorrelations of scale items are displayed in Appendix B, Table B.1. Correlations between scale items ranges from 0.01 to 0.41. Twelve of the fifteen correlations are statistically significant. Since the correlations indicate that the items are tapping a common dimension of fear of crime, they were combined into an additive scale, which has a range of 0-10 (two of the items have a maximum value of 1 and four items a maximum value of 2).

On the initial interview, the mean score on the fear index was 5.20, while on the final interview the mean dropped to 4.61.

This difference is significant at the 01. level (paired t= 3.16, with 245 degrees of freedom). Thus, the fear of crime index does appear to be sensitive to the readjustment process and is therefore a potentially useful measure for examining the effects of counseling.

A second index of behavioral adjustment was created, based partly on a similar scale employed by Smith and Cook (1985). Items in the index used in the present study covered the following areas:

- Job performance
- Relating to spouse
- Accomplishing daily chores
- Keeping appointments
- Parenting
- Making decisions
- Relating to people at work
- Solving problems

Table B.2 in Appendix B displays intercorrelations among the items, which range from 0.22 to 0.67. The high inter-item correlations suggest that it is legitimate to combine the items into a single index. This was accomplished by summing the scores from each individual item, which had values from 0 (indicating no difficulty in a particular area of adjustment) to 2 (indicating "a lot" of difficulty).

The mean score for the behavioral adjustment index on the initial interview was 2.09, the equivalent of "a lot of difficulty" in one area of adjustment. By the time of the follow-up

interview, the average score had dropped to 1.70, a decline significant at the .05 level (paired t = 1.71, with 245 degrees of freedom). Thus the behavioral adjustment index also appears to be a useful gauge of post-crime recovery and of the effects of counseling.

On neither the fear of crime or the behavioral adjustment index were there any statistically significant differences between groups prior to treatment (F=0.67, df=3,242 for the fear index; F=0.14, df=3,242 for the behavioral adjustment index).

Post-treatment, we might expect to find greater reductions in both of these indices in the two counseling groups than in the Material Assistance Only or the Control groups. Table 3.9 presents the post-treatment results, both for the entire sample and for the half of the sample exhibiting the most severe symptomatology on the SCL-90R overall score. Neither for the entire sample nor for the half with the most severe symptoms were there significant differences between treatment groups on either index. For the behavioral adjustment index, differences between means were in the expected directions, but this was not true of the fear of crime index.

Thus, the results for the two created indices confirm the findings for the standardized scales of psychological adjustment. That is, we have no evidence that the counseling received by victims in the study promoted psychological healing.

TABLE 3.9: DIFFERENCES BETWEEN GROUPS ON FEAR OF CRIME AND BEHAVIORAL ADJUSTMENT INDICES AFFTER TREATMENT

	Control (n=48)	Material Assistance Only (n=55)	Crisis Counseling (n=53)	Cognitive Restructuring (n=25)	Significance [1]
Fear of Crime Index	4.50	4.73	4.49	4.80	F(3,177)=0.11
Behavorial Adjustment Index	2.33	1.75	1.30	1.24	F(3,177)=1.44

Half of Sample with Highest Scores on Global Symptom Index of SCL-90R

	Control (n=20)	Material Assistance Only (n=25)	Crisis Counseling (n=26)	Cognitive Restructuring (n=15)	Significance [1]
Fear of Crime Index	5.10	5.72	5.69	5.33	F(3,82)=0.26
Behavioral Adjustment Index	3.25	2.24	1.96	1.46	F(3,82)=1.27

1. No differences approached statistical significance.

3. Perceptions of the Victimization Experience

Included in the pre- and post-treatment assessments were a number of questions that tried to get at how victims appraised their experience. As discussed in the first chapter, there is considerable evidence that how people view a catastrophic event predicts their psychological and even physical health in the months and years following the event. Data from this study relevant to that issue will be dealt within Chapter 5.

Here we will look at a somewhat different question: Does counseling encourage victims to view their experience in constructive ways that may facilitate their psychological adjustment? Or, looked at in another way, can the ability to view catastrophic experiences in a more positive fashion be taught to crime victims? Certainly this is the point of cognitive restructuring, which is based on the premises that (a) distress is not a function of circumstances, but on the way that people view their circumstances and (b) that these views can be altered and by so doing, distress will be reduced or eliminated. Crisis counseling, on the other hand, is not directed primarily at changing perceptions. Still, it does attempt to help victims understand the crisis and their reactions and to help them to develop ways to cope with the crisis. For example, VSA counselors often stress to victims that they are not responsible for the crime and therefore have no reason to feel ashamed,

guilty, or that the crime is punishment for acts of commission or omission.

Therefore, cognitive restructuring would be expected to have the greatest effect on how people view their victimization, and crisis counseling to have a lesser effect. To test this idea, questions were constructed that were relevant to tapping several dimensions suggested in the literature of ways that people perceive crises that do or don't facilitate adjustment. This aspect of the study was intended to be exploratory in nature. Because we were looking only for clues to guide future research, and not for definitive answers in this study, we did not attempt rigorous measurement of these dimensions.

The first dimension measured was whether respondents blamed themselves for their victimization. From the literature review presented in the first chapter, there appears to be a consensus that self-blame in some way affects the recovery process and that behavioral self-blame (i.e., blaming the crime on specific behaviors that the victim can readily alter), in particular, may facilitate recovery.

In the present study, two questions were included on self-blame. One was general ("Do you feel responsible for what happened?") and the other aimed at identifying behavioral self-blame ("Is there anything you could have done differently to have

prevented the crime from happening?"). Since VSA counselors actively discourage victims from blaming themselves, it was expected that victims in the Crisis Counseling and Cognitive Restructuring groups would show a reduction in self-blame from initial to follow-up interview, relative to victims in the Material Assistance Only and Control groups.

A second dimension of victim perceptions measured in the study was based on the notion of "selective evaluation" (Taylor, et. al., 1983). As discussed in the introduction, this idea proposes that victims seek to minimize their distressed state through a process of focusing on positive aspects of the situation.

The present study included five items constructed to assess each aspect of the "selective evaluation" process described by Taylor, et. al. We would expect victims who received counseling--especially those in the Cognitive Restructuring group to show a greater tendency to "selectively evaluate" their experience on the follow-up interview than victims in the Control or Material Assistance Only conditions. The items included:

- What happened to me really wasn't that bad compared to what some victims go through.
- Since your experience as a crime victim, do you feel any better able to handle yourself in a crisis?
- In a way, I was lucky things didn't turn out worse for me than they did.
- We know that being a victim of a crime can be a very bad experience. But, are there any positive things you can

think of that resulted from your experience?

° Under the circumstances, I think I'm handling things pretty well.

A third dimension of victim perception included in the study was the extent to which victims experienced a sense of control over their lives. Both the crisis counseling and cognitive restructuring techniques aim to give victims greater control over their situations. Thus we would expect to see differences in victims' sense of control between these two conditions on one hand, and the Material Assistance Only and Control conditions on the other hand, at the time of the follow-up interview. Questions included on the assessment to measure victims' sense of control over what occurred in their lives included:

° Since the crime, do you feel less control over your life?

° How likely is it that you will be a crime victim in the next year?

Table B.3 displays inter-item correlations for the self-blame, the selective evaluation and the life control questions. The correlation between the two self-blame items was quite high (0.51). But correlations between selective evaluation items are very low (ranging from 0.02 to 0.29). Only two of the correlations reached satistical significance. Because the items are not strongly related, no effort was made to combine them into a single scale. The correlation between the two life control items was also quite low (-.06).

Table 3.10 examines changes in victims' perceptions of their experience from the first to second assessments. What is striking about the data in the table is the almost complete lack of change in perceptions. Not one measure changed significantly over the three months between first and second interviews. Nor were they influenced by the treatments used in the study: An examination of perceptions over time broken down by treatment groups revealed no significant exceptions to the overall pattern of stability over time.

Thus, victims' views of their experience are not correlated with changes in psychological adjustment that we have seen occurs during the months following the crime. Rather, they seem to be relatively stable aspects of how individuals respond to crisis. This suggests that they may be useful as predictors of subsequent adjustment. That issue will be explored in Chapter 5.

D. Respondents' Evaluation of Services

We have failed to see any evidence that services received by victims reduced practical problems they were experiencing as a result of the crime or affected their psychological adjustment, as measured by paper and pencil tests. A third type of measure of the utility of services is very straightforward: Did victims feel that the services were helpful?

The answer is, "yes". Among all victims assigned to one of the three service groups (Crisis Counseling, Cognitive

TABLE 3.10: COMPARISONS BETWEEN INITIAL AND FOLLOW-UP ASSESSMENTS IN RESPONDENTS' PERCEPTIONS OF VICTIMIZATION

	Initial Assessment	Follow-up Assessment
Self-Blame		
Feel responsible for what happened? (n=178)		
Yes	31%	33%
No	69	67
Could anything have been done to prevent crime? (n=179)		
Yes	55	55
No	45	45
Selective Evaluation		
What happened wasn't so bad compared to others (n=179)		
Yes	61	67
No	39	33
Better able to handle yourself in a crisis? (n=159)		
Yes	43	48
No	58	53
Lucky things didn't turn out worse (n=180)		
Yes	79	79
No	21	21
Anything positive result from experience? (n=174)		
Yes	72	64
No	38	36
Handling things well under circumstances (n=180)		
Yes	79	76
No	21	24
Control Over Life		
Feel less control (n=179)		
Lot less	16	13
Little less	20	14
Same	64	72
Likely to be a victim during next year (n=110)		
Very likely	17	12
Somewhat likely	28	29
Unlikely	44	41
Other/don't know	11	18

Restructuring, or Material Assistance Only), 89% rated the services they received as "extremely helpful" or "somewhat helpful".

Quotes from several victims on the follow-up interview support this statistic. One woman who lost money, jewelry, and clothes in a burglary exclaimed during the initial interview, "I am desperate." She said that $30 cash assistance she had received form VSA was "extremely helpful" in carrying her through a very rough period. Likewise, another woman remarked, "The $20 I got from VSA helped me to buy food until I received my public assistance grant."

It is also interesting to note that a significantly higher proportion of victims rated Cognitive Restructuring as "extremely helpful" than rated Crisis Counseling as "extremely helpful", 68% versus 40% ($p=.04$, by Fisher's Exact Test). But it was also apparent that some counselors received much higher ratings from victims than others. For example, among the four counselors with the most cases in the study, two received "extremely helpful" ratings in more than 60% of their cases (10 of 14 for one counselor and 7 of 11 for the other), while the other two received "extremely helpful" ratings in less than 40% of their cases (4 of 10 for one counselor and 1 of 6 for the other). (Interestingly, the two counselors with the highest ratings were the two with masters degrees and the two who--as the next

chapter describes--adapted most readily to the cognitive restructuring technique.)

To ensure that the higher rating given to the Cognitive Restructuring condition was not a function of individual counselors, we examined separately the Cognitive Restructuring and Crisis Counseling cases of the two most highly rated counselors. When administering cognitive restructuring counseling, these two counselors received an "extremely helpful" rating from 12 of 14 victims (86%), compared to 5 of 11 victims (45%) when administering crisis counseling. This difference did reach statistical significance ($p=.04$, by Fisher's Exact Test).

E. Discussion

It is disappointing that we did not observe effects of services either on victims' psychological adjustment or on their material adjustment. But there a variety of factors that together may have made treatment effects difficult to observe.

One difficulty in measuring the effects of material assistance is that material problems for most victims were ameliorated--regardless of whether or not services were received--within the three months that passed between first and second assessments. In other words, the vast majority of victims of the types of crimes studied here recover from practical problems sooner or later: The realistic question about material

assistance is whether it can hasten that process. To answer that question, a one-month interval between assessments might have served far better than the three-month interval used.

Benefits of material assistance may also be difficult to isolate because of the difficulty in constructing adequate measures. The reason it is difficult to construct good measures is because the services most frequently provided really address a fairly narrow range of victims' practical needs. Many victims, for example, reported having problems making ends meet, but VSA can do only a limited amount for these people: It can refer them to the welfare emergency assistance program (which most people on welfare are probably already aware of); it can assist them in filing a claim for compensation from the state (but the process is lengthy and does nothing for their immediate problem of paying the rent or other bills); and it can provide a small amount of cash aid (which is usually insufficient to cover victims' financial shortfalls). Similarly, lock repair/replacement or referrals for security surveys by the police do not, apparently, address in a major way the problem of vulnerability and fear of revictimization that many respondents expressed.

That is not to say that services don't help--victims certainly felt that they did. But the most common problems of making ends meet and fear of revictimization are still ones that people must deal with largely on their own or with some help from their

family and friends. As one woman put it, "There's nothing that nobody can do, really. You have to do it for yourself--that's the way I feel."

Some of the same factors may have applied to the failure to find effects of counseling on victims' psychological adjustment. Distress levels had declined quite dramatically for all victims between the first and second assessments--possibly approaching pre-victimization levels. To measure effects of counseling a shorter follow-up interval might have been advantageous. Among the types of victims in this study, the question for counseling, as with material aid, may not be "Does it help victims to recover?" but rather "Does it help victims to recover faster?"

Another reason for not detecting an effect of counseling may have been that the intervention--when looked at in terms of just one or two sessions attended--was very weak. Studies finding significant outcome effects of therapy in other fields have typically looked at interventions lasting a <u>minimum</u> of a half-dozen hours of treatment. It is probably unreasonable to expect that one to two sessions can have demonstrable aggregate effects on measures of psychological adjustment. Indeed, it is encouraging that there was some evidence of a weak relationship between the number of counseling sessions received and psychological outcomes among victims assigned to one of the counseling conditions.

Compounding the problem of weak treatment effects, is the fact that victims in the Control group did not constitute a true no-treatment control: These victims did spend 45 minutes or more with a research interviewer completing the initial assessment, a process that may have had some therapeutic value in and of itself. (Evidence for the therapeutic effect of psychological assessments is limited: Such an effect was reported by Atkeson, et. al., 1982, but no such effect was observed in studies by Calhoun, et. al., 1982; or by Resick; et. al., 1981; or by Kilpatrick, 1984.) It certainly would have been desireable to include a group that received a follow-up assessment only to determine whether any therapeutic effects of the inital psychological assessment might have masked affects of the counseling. Unfortunately, limited funds did not permit inclusion of such a group.

On the positive side, most victims believed that the services they received were helpful, a result also found in Smith and Cook's (1985) study of on-scene crisis counseling for victims. It is noteworthy that the cognitive restructuring technique was rated helpful significantly more often by victims than crisis counseling without the added cognitive technique. The next chapter discusses in detail how the cognitive restructuring method was received by counselors, and how they integrated it into their work.

Chapter III Footnotes

1. The greater proportion of victims attending more than one session in the Cognitive Restructuring group is, in part, attributable to the reassignment to the Crisis Counseling condition of 14 victims originally in that group but who did not receive cognitive restructuring. The reason that these 14 victims did not receive cognitive restructuring is that counselors did not believe they were ready to handle cognitive restructuring during the first counseling session, but the victims failed to return subsequently.

2. VSA clients victimized by domestic violence and rape, however, usually receive multiple counseling sessions.

IV. COUNSELORS' EXPERIENCE WITH THE COGNITIVE RESTRUCTURING TECHNIQUE

The cognitive restructuring counseling method used in the study was intended to be a technique which could be readily applied by any victim program providing crisis intervention services. For that reason, a clinical psychologist versed in cognitive restructuring taught the method to VSA crisis counselors, rather than apply the technique himself. In keeping with the idea of developing a method which could be applied widely, training of VSA counselors was relatively brief, consisting of two two-hour group instructional sessions and one individual session with each participating counselor.

The results of the effort to train crisis intervention workers in a new and alien cognitive technique were mixed. Certainly the fact that counselors did not use the technique with 14 of 48 victims assigned to the cognitive restructuring condition is an indication that they had difficulty with it. Counselors did not view cognitive restructuring as applicable to all situations, and some had problems integrating the technique into their counseling sessions. But other counselors had little difficulty with the technique, and the consensus was that it was a useful tool to have available in working with victims.

The analysis below is based on two sources. The first was a group discussion with counselors that participated in the study,

held after the data collection phase was completed. The second source is a formal questionnaire that counselors were asked to fill out summarizing their experience with the cognitive restructuring technique.

A. Situations Where the Technique Worked

The consensus among the counselors was that cognitive restructuring worked best in situations where victims recognize that they are experiencing debilitating emotions or behaviors and are highly motivated to do something about them. Several counselors noted that such victims tended to be ones who had a high level of functioning prior to the crime and/or ones who already have gained insight into themselves as a result of previous experience with counseling or therapy. In other words, counselors felt, cognitive restructuring was appropriate for victims who were looking for a way to regain greater control over their lives.

One counselor found the technique particularly useful for helping clients to deal with the tendency to blame themselves for their victimization. She said that the process of completing the cognitive restructuring worksheet invariably uncovered the fact that clients believed they had somehow caused--or failed to prevent--their victimization. The counselor then pressed the clients to talk about what they could have done to avoid vic-

timization. According to the counselor, this process made the clients realize that there really was nothing they could have done to prevent the crime. As she put it, if they knew what was going to happen, they never would have been in that situation in the first place.

Probably the biggest "success story" for cognitive restructuring involved the case of a mugging victim who felt suicidal. The counselor's description of the case ran as follows:

> This woman said, um, that she was mugged by two guys. I think they had a gun or something. And her feeling--the consequence of it was that she was feeling suicidal--"I don't think life is worth living," or something like that.... [In the process of using the cognitive restructuring form] it turned out...that she felt, as a result of this mugging, that she couldn't come in and out of the building; she couldn't trust anybody. So what she'd done was she had stopped going to the races; she stopped visiting her family; and she stopped walking around on Fordham Road and going shopping.
>
> And the connection that was made, that was so exciting to both of us, was that the reason she was feeling like killing herself was that she had cut herself off from all of the activities that she had ever done before; and the only way she could feel better about herself was to resume these activities.
>
> [I asked her if she wanted] to live like this! "No!" "But what can you do to stop feeling like this?" "Well, I can start going betting on the horses again. I can, you know, go shopping on Fordham Road." So she ended up thinking that her way of reacting was what was making her feel so bad; and that she didn't have to react that way. That yes, she could be scared, and, yes, she could be cautious; but it doesn't mean you have to cut off your friends and family and stop betting on the horses.

> I saw [the cognitive technique] as....a way of empowering her in being able to function a little bit better in other areas of her life, while at the same-time recognizing all [the emotional problems that were] there. But I thought it was helpful. It was helpful for me, cause I felt like I had done at least one thing that was helpful to her and I think she felt better, too.

B. Situations Where the Technique Didn't Work

Of course, not all of the counselors' attempts to apply cognitive restructuring were as successful as the case described above. Counselors reported that some victims felt threatened by the technique because it was confrontive (i.e. counselors challenged "irrational" beliefs) and/or they didn't understand its purpose. Adverse reactions appeared to be most common among victims who had been severely traumatized. Counselors believed that such victims needed to "ventilate" and be reassured before they could begin to clearly analyze their situations via cognitive restructuring.

At the opposite extreme, counselors noted that the technique was inappropriate for some of the victims they saw because the victims did not appear to be experiencing negative emotions or maladaptive behaviors. This relates to decisions about the research design, discussed in the previous chapter, which resulted in the inclusion of some victims in the sample who had no apparent adjustment problems.

Another group of victims for whom counselors expressed reservations about cognitive restructuring were victims who had little education. Such victims, counselors reported, were sometimes uncomfortable with the technique because they had difficulty understanding its purpose, could not write well enough to fill out the cognitive restructuring form, or felt they would be judged by their "performance" on the task. Other counselors felt that the technique was inappropriate for less educated victims because they were not accustomed to analyzing their thoughts or motivations: "The clients I deal with don't rationalize things," reported one counselor.

Finally, counselors reported that cognitive restructuring was awkward for victims who had urgent practical problems. As one counselor put it, "... they're thinking more like... 'How can I pay my rent?', not 'How do I <u>feel</u>?'

Many of the problems reported with the use of cognitive restructuring were the result of the artificial situation created by the experiment. Counselors were urged to use the technique during the first session with victims because it was not known whether victims would return for additional sessions. In a more natural environment, it would have made more sense to introduce cognitive restructuring in later sessions for severely traumatized victims or for victims with pressing material needs.

C. How Counselors Adapted to Cognitive Restructuring

Most of the counselors seemed to experience some difficulties adapting to the use of cognitive restructuring. As one counselor put it, "It's hard enough when someone is falling to pieces and needs to be organized to use what tools you have [let alone] a new technique."

Counselors tended to find it awkward to introduce the technique. Rather than using cognitive restructuring to shed light on issues as they developed in the course of a session, counselors often introduced the technique abruptly at the end of a session. One reason for this was that counselors did not always believe that the technique was appropriate to introduce in the first session with a client, as mentioned above. Nonetheless, they felt compelled to do so because of the research project.

The rather minimal training that counselors were given in the use of cognitive restructuring seems to have contributed to their awkwardness with the technique. Some counselors stated that they did not feel confident with their mastery of the technique and that they would have benefited from more extended training. One of the tapes of cognitive sessions indicated this clearly. After a long silence in the midst of completing the cognitive restructuring form, the counselor said to the client:

> Okay, I'm very new at using this thing....It's difficult to work with this because in our regular technique of working we just talk without actually having to think about every little thing.

Several counselors also were not themselves convinced that cognitive restructuring was beneficial to clients: One counselor worried that cognitive restructuring would harm clients by shattering thought patterns that served as "defenses." Another counselor said, "I don't feel that most of us ever felt comfortable with the technique because we didn't understand the relevance or concepts behind it. Therefore it felt intimidating."

On the other hand, two of the counselors adapted quite readily to using cognitive restructuring and were able to integrate the technique smoothly into counseling sessions. One saw it as a way of focusing on issues that had come out in the course of a session: "I'd tell them that there was a way of making some sense of everything we had talked about and getting a handle on understanding why they were reacting in a particular way."

The other counselor who successfully integrated the technique into her sessions introduced it early in sessions within the context of probing clients' reactions to victimization. She began by asking the victim to imagine that the two of them were in a hypothetical work situation in which they were each criticized by a co-worker. The counselor created a scenario in which the victim reacted constructively to the criticism, while the counselor reacted in a negative manner. The counselor then pointed out that the difference in reactions was due to how the two individuals

in the hypothetical situation thought about the criticism. What is interesting is that by portraying herself in the example as the one having the counterproductive, irrational response, the counselor sought to communicate that it was all right to express any such thoughts or feelings that the client might be having about the victimization.

The counselor then went through the process of filling out the cognitive restructuring form with the client, taking pains to reinforce several times the connections they had established between events, thoughts, and reactions. She stressed the intensive effort that she felt was necessary to make the cognitive technique work:

> ...I was working as hard as they were. I mean, I was really participating. I was wiped out, you know, thinking along with them...in a couple of those cases like both of us discovered something together. And we both got it. Both of us felt really happy with ourselves. We felt, like, 'Wow'! Is that really what's going on?

D. Discussion

The experiment to introduce a new counseling technique to trained crisis intervention workers had mixed results. By the end of the study, two of the counselors were enthusiastic about cognitive restructuring, and all but one saw it as a useful tool for their future work. So the technique seems to have good potential for work with crime victims.

Many problems arose, however, with the use of the cognitive technique in this particular experiment. One set of problems centered around the demands of the research study which dictated that the technique be universally applied. This experience shows that cognitive restructuring may not be appropriate in first sessions with severely traumatized victims. Moreover its use with less educated victims would need to be carefully weighed and methods developed to reduce its threatening appearance to this population. This is a significant issue for VSA which deals with many victims without much education, as do most victim service programs.

This experiment also made it clear that training crisis intervention workers in cognitive restructuring needs to be more extensive than just two group sessions and one individual session. The orientation of crisis intervention workers at VSA is very different from that required for cognitive restructuring. Some crisis intervention workers in offices that service low income clients are involved primarily in the delivery of material assistance. For them, cognitive restructuring requires a far more "psychological" approach than they are used to. Other crisis intervention workers are accustomed to dealing with victims' psychological needs, but they approach these needs from the standpoint of crisis theory, which incorporates assumptions that differ in some respects from those made in cognitive therapy.

For example, crisis theory suggests that expressing negative emotions, or "venting", has a cathartic effect while cognitive restructuring encourages clients to analyze and alter these reactions. Crisis theory assumes that defenses may be necessary for clients to cope, while cognitive restructuring may challenge thought or behavior patterns seen as maladaptive.

Thus, training of crisis intervention workers in cognitive restructuring must do more than merely instruct them how to use the technique. It must first convince them that the approach itself is a useful one. In this respect it is interesting to note that the two counselors who most readily adapted to cognitive restructuring were individuals who had had the greatest amount of formal education and who already had some familiarity with cognitive therapies prior to the study. For most crisis intervention workers, however, being comfortable with this technique may take considerable exposure.

V. PREDICTING RECOVERY

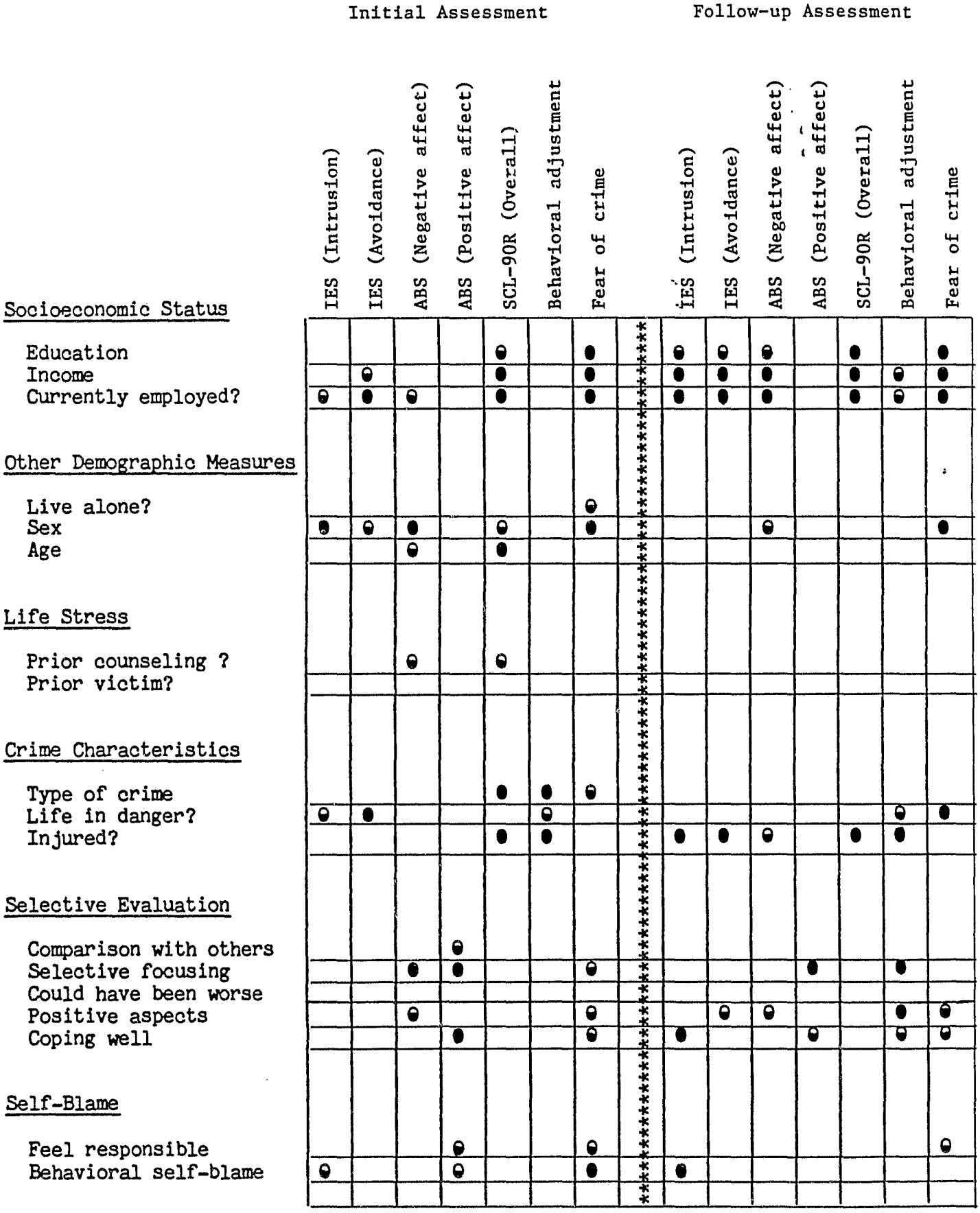
We have not seen evidence that counseling received by victims in the study enhanced recovery three months post-crime. We have noted that this was because--counseled or not--victims had recovered substantially from the crime three months later. Still, the degree of recovery on the follow-up interview did vary from victim to victim. In this chapter, we take up the question of whether it is possible to predict which victims are likely to show high or low amounts of psychological distress both shortly after the crime and three months later. More specifically, are there particular characteristics of respondents, of victimizations, or of the way respondents perceived victimization that are likely to result in high or low distress?

A. Looking at the Effects of Predictors One at a Time

To facilitate the analysis, only non-redundant summary measures of psychological adjustment were examined. These include the Intrusion and Avoidance scores from the Impact of Event Scale; the overall Positive Affect and Negative Affect scores from the Affect Balance Scale; the Global Symptom Index from the Symptom Checklist 90R; and the crime fear and behavioral adjustment indices created for this study.

Table 5.1 summarizes the relationships between individual predictors and measures of psychological distress. Because of

TABLE 5.1: SUMMARY OF RELATIONSHIPS BETWEEN INDIVIDUAL PREDICTORS AND MEASURES OF PSYCHOLOGICAL DISTRESS.



amount of data in the table is massive, we have not presented the analysis of variance results for each relationship. Rather each relationship is summarized only as being significant at the .01 confidence level (filled circle), significant at the .05 confidence level (half-filled circle), or not statistically significant (no circle).

The socio-economic indicators of education, income, and employment status were statistically significantly predictors of a number of distress measures, especially overall symptoms on the SCL-90R and fear of crime. Respondents with relatively little education, with low incomes, and without jobs consistently showed greater levels of distress than victims in relatively higher socio-economic groups.

Of the other demographic measures included in the study, sex was most highly predictive of psychological distress at the initial interview, with women more distressed than men. Age was also significantly related to two measures of distress at the initial assessment. Surprisingly, however, the relationships were inverse ones: That is, older victims were <u>less</u> distressed (in terms of negative mood states and overall symptoms on the SCL-90R) than younger victims. Victims who lived alone were less fearful of crime than those who lived with others, but otherwise no significant differences were apparent according to victims' living status.

Life stress measures overall were not strongly related to distress. The exceptions were that victims who had sought professional help for an emotional problem within the past year exhibited greater negative affect and more overall symptoms on the SCL-90R than other victims. Being a victim before was not significantly related to any outcomes measured.

Crime characteristics--including type of crime injury, and life threat--were each associated with several measures of distress. Victims showing the greatest distress were those who were victims of personal crimes (rape, robbery, or assault), who had been injured, and who felt that their life had been in jeopardy while the crime was being committed.

Several measures of victims perceptions each were associated with several measures of victim distress. In general, those who were able to find something positive in their situation and those who felt that their behavior had contributed to their victimization were less distressed than victims who found little to value in their plight or who did not accept some responsibility for becoming a victim. Unlike the other predictors, victim perceptions tions were tied not only to the degree of distress but also to the presence or absence of positive mood states: That is, victims who emphasized the positive and who attribute responsibility to themselves showed more positive affect than victims who lacked these perceptions.

B. Looking at the Effects of Predictors While Controlling for the Effects of Others

Looking only at relationships between individual factors and victims' psychological states gives incomplete information about predicting recovery. The reason is that some predictors may be correlated with each other, as well as with psychological outcomes. For example, we just noted that being female is a good predictor of distress and so is poverty. But it may be that poverty is the real cause of distress, and sex is only spuriously associated with distress because more women than men tend to live in poverty.

In fact, many of the predictors used in the analysis were correlated. For example, victims were significantly more likely to blame themselves if they were burglary victims rather than victims of violent crimes (43% vs. 27%)[1]; if they were better-educated and more affluent (75% of victims who had graduated college blamed themselves compared to 43% of victims who had not finished high school; 68% of victims with annual household incomes exceeding $20,000 blamed themselves compared to 50% of victims with household incomes under $10,000)[2,3]; and if they were crime victims previously rather than first-time victims (64% vs. 46%).[4]

The tendency of victims to "selectively evaluate" their experience was also related to demographic factors, in particular

socio-economic status and age. Victims with jobs were more likely than those without to believe that what happened to them wasn't so bad compared to what some victims go through (68% vs. 56%).[5] And victims with household incomes in excess of $20,000 per year were more likely than those with incomes of less than $10,000/year to believe they were lucky things didn't turn out worse (85% vs. 75%)[6] and that they were handling things well under the circumstances (84% vs. 72%).[7] Finally, older victims--especially those over 60 years of age--were more likely than victims under 30 to believe they were lucky things didn't turn out worse (90% vs. 72%)[8] and that as a result of their experience they were better able to handle themselves well in a crisis (43% vs. 28%)[9].

In order to assess the <u>independent</u> effect of each predictor (that is, the effect of that predictor while holding constant other predictors), heirarchical multiple regression analysis was used. In the analyses, predictors were grouped into conceptual categories. These categories, or <u>blocks</u>, included socio-economic measures, other victim demographic characteristics, measures of life stress, factors associated with the crime, "selective evaluation" indicators, and self-blame[10] measures.

The results of the regression analyses include two ways to look at the relative importance of predictors in explaining variation in psychological outcomes. First, the relative

importance of each predictor is represented by its standardized regression coefficient. The larger the coefficient, the greater the importance of that predictor. Second, each block of predictors has associated with it a measure of the explanatory power of that block in predicting psychological outcomes. That measure, or R^2, is the unique percentage of variation in psychological outcomes attributable to each predictor block. It represents the additional explanatory power given to the regression model by adding a particular block to the equation, while taking into account the effects of all other blocks. It should be noted that this process does not attribute some of the variation in psychological outcomes explained by the overall model to any particular predictor or block of predictors. This portion of the explained variation is due to interrelated components of the predictors, or multicollinearity. Thus in each analysis, the overall amount of variation explained in psychological outcomes will always be greater than the sum of the R^2 values associated with each block of predictors.

In examining the individual effects of predictors upon recovery, we looked at seven different measures of psychological adjustment at both the initial and follow-up assessments. Actually, there is a good deal of redundancy in those measures. Table B.4 in Appendix B presents intercorrelations of the seven measures of adjustment from the initial assessment. In fact,

six of the seven measures--those indicating psychological difficulties--show consistent, high intercorrelations, ranging from 0.22 to 0.77. In stark contrast, one measure--the Positive Affect total of the Affect Balance Scale--does not correlate significantly with any other measure. This confirms the notion that positive affect is independent of negative affect; that is, the amount of joy, contentment, affection, and vigor people experience is not just the inverse of the amount of negative affect (depression, anxiety, hostility, and guilt) they are experiencing (Bradburn, 1968). Because the six measures of psychological difficulties are highly correlated, we will choose just one of them--the Global Symptom Index (GSI) of the symptom Checklist 90-R--to reduce redundancies in the multivariate analyses. We will, then, be conducting four analyses, predicting GSI scores from the SCL-90R and positive affect scores from the ABS, each at initial assessment and follow-up assessment.

The results of the multivariate effort to explain GSI scores from the SCL-90R are presented in Table 5.2. At the initial assessment, the most important blocks of predictors were demographic and socio-economic measures, explaining 7.1% and 5.3% of the variance in GSI scores. All other blocks of variables explained less than 5% of the variance. Among the strongest individual predictors were sex (women were more distressed than men), age (young victims were more distressed than older

TABLE 5.2: MULTIVARIATE PREDICTION OF SCL-90R GLOBAL SYMPTOM INDEX SCORES AT INITIAL AND FOLLOW-UP ASSESSMENTS

	Initial Assessment		Follow-Up Assessment	
	Standardized Regression Coefficient	Percent of Variance Explained (R^2 x 100)	Standardized Regression Coefficient	Percent of Variance Explained (R^2 x100)
Demographics		7.1%		1.3%
Live alone?	0.08		0.01	
Sex	0.19**		0.03	
Age	-0.22**		-0.12	
SES		5.3%		11.3%
Education	-0.05		-0.12	
Income	-0.19**		-0.27**	
Currently employed?	-0.11		-0.11	
Life Stress		0.8%		1.5%
Prior counseling	-0.03		-0.06	
Prior victim	-0.09		-0.12	
Crime Characteristics		3.7%		5.4%
Type of Crime	-0.02		-0.07	
Life in danger?	0.07		0.20*	
Injured?	-0.23**		-0.25**	
Selective Evaluation		4.9%		1.3%
Comparison with others	0.07		0.06	
Selective focusing	0.13		-0.01	
Could have been worse	-0.12		-0.10	
Positive aspects	0.05		0.08	
Coping well	0.07		0.02	
Self-Blame		0.0%		0.4%
Behavioral self-blame	0.01		0.06	
Overall		30.9%		27.2%

Degrees of freedom=144

* Significant at .05 level.
** Significant at .01 level.

victims), income (poor victims were more distressed than more affluent victims), and injury (injured victims were more distressed than victims not injured).

Predicting victim distress on the follow-up interview was nearly as successful as prediction of distress on the initial interview: We were still able to explain 27% of the variance in GSI scores, compared to 31% at the initial assessment. The pattern of importance of predictors, however, changed markedly. At the second assessment the block of socio-economic measures was by far the most important set of predictors. In fact the amount of variance explained by socio-economic factors actually increased over time, from 5.3% initially to 11.3% on the follow-up interview. Again, income was the strongest individual predictor from this group. The only other block to explain more than 5% of the variance was the one containing crime characteristics, which at the follow-up assessment accounted for 5.4% of variance in GSI scores. Within this block, injury remained the strongest individual predictor, but at the follow-up assessment victims' belief that their life had been in danger during commission of the crime also attained statistical significance as an individual predictor. Demographic factors which had been the most powerful predictors of distress at the initial assessment explained very little variance by the time of the follow-up assessment.

Table 5.3 presents the results of the efforts to predict positive affect totals on the Affect Balance Scale. The first

TABLE 5.3: MULTIVARIATE PREDICTION OF ABS POSITIVE AFFECT TOTAL SCORES AT INITIAL AND FOLLOW-UP ASSESSMENTS

	Initial Assessment		Follow-Up Assessment	
	Standardized Regression Coefficient	Percent of Variance Explained (R^2 x 100)	Standardized Regression Coefficient	Percent of Variance Explained (R^2 x100)
Demographics		2.8%		3.9%
Live alone?	0.05		-0.03	
Sex	0.05		0.12	
Age	0.20**		0.18*	
SES		0.1%		0.6%
Education	0.04		-0.06	
Income	-0.06		0.06	
Currently employed?	-0.05		-0.10	
Life Stress		0.4%		2.2%
Prior counseling	-0.06		0.15*	
Prior victim	0.05		0.05	
Crime Characteristics		0.8%		3.0%
Type of Crime	-0.14		-0.08	
Life in danger?	-0.09		-0.24**	
Injured?	-0.05		0.08	
Selective Evaluation		12.5%		10.6%
Comparison with others	-0.05		0.02	
Selective focusing	-0.27**		-0.28**	
Could have been worse	-0.10		-0.10	
Positive aspects	0.13		0.14	
Coping well	-0.20**		-0.10	
Self-Blame		1.5%		3.0%
Behavioral self-blame	-0.07		-0.10	
Overall		17.1%		20.0%

Degrees of freedom=140

* Significant at .05 level.
** Significant at .01 level.

thing to observe is that the amount of variance explained is considerably lower than it was for the GSI scores--17% at the initial assessment and 20% at the follow-up assessment. The second thing to note is that quite different blocks of predictors are important in explaining positive affect scores than were important in explaining GSI scores. At the initial assessment, the "selective evaluation" block explained 12.5% of the variance in positive affect, and was the only block to explain more than 5% of the variance. The most important individual predictors in this block included victims' belief that this experience had made them better equipped to handle themselves in a crisis and that the belief that they were handling things well under the circumstances. Only one other individual predictor--age--attained statistical significance: Older victims tended too have higher levels of positive affect than younger victims.

The relative importance of blocks of predictors remained pretty much the same at the follow-up assessment. Selective evaluation measures still accounted for 10.6% of the variance in positive affect scores, and again no other block exceeded 5%. Two new individual predictors attained statistical significance at the follow-up assessment. Victims who believed that their lives had been in danger during the crime and victims who had sought professional help for an emotional problem during the year prior to the crime had lower positive affect scores than other victims.

C. Discussion

The efforts to predict psychological adjustment confirm several of the findings of earlier studies. Like the studies by Friedman, et. al. (1982) and Harrell, et. al. (1985), the present study found tht women exhibit more post-crime trauma than men, at least in the initial weeks after the crime. Like the Harrell, et. al. and Friedman, et. al. studies the present study also found that socio-economic status is a significant predictor of distress, and that the disparaties in distress between more and less affluent victims become larger at least for several months after victimization. It appears, in other words, that less affluent victims recover from the effects of crime less quickly than more affluent victims. An alternative explanation is that both more and less affluent victims had recovered to baseline (i.e., pre-crime) levels of distress by the time of the follow-up assessment, but the baseline for low socio-economic victims was much lower than for high socio-economic victims. Without normative data for non-victims of demography comparable to the victim sample, it is impossible to distinguish with assurance between explanations of the gap between high and low socio-economic victims.

In other respects, the findings of this study are in disagreement with some previous research. Unlike research by Atkeson, et. al. (1982), Frank, et. al. (1981), Ruch and Chandler

(1983), and Kilpatrick, et. al. (1985), the present study found that factors associated with the crime including--injury and the victim's perception of threat to life--had a negative impact upon recovery. Further, this study did not, in general, find the strong deleterious effect upon recovery of pre-crime life stress that has been found by most other researchers (Calhoun and Atkeson, 1981; McCahill, et. al., 1979; Frank, et. al., 1981; Harrell, et. al. 1985; Kilpatrick, et. al. 1985). Very likely, this discrepancy has to do with the fact that other studies have employed more sophisticated life-stress measures than were used here.

Probably the most interesting finding in this section is the fact that how victims perceive their experience does seem to affect, if not their level of distress, at least their level of positive affect during the post-crime period. Although several authors have suggested such a link (e.g., Taylor, et. al., 1983; Wortman, 1983; Janoff-Bulman, 1979), to our knowledge this is the first study of crime victims to empirically validate the link. It is especially significant because the relationship between victim perceptions and recovery were not a true focus of the study and the measures of perceptions were accordingly rough.

The finding linking victim perceptions to psychological adjustment has exciting implications for programs that counsel victims: If some victims have cognitive "styles" of responding

to crisis that facilitate recovery, can these adaptive thought patterns be taught to other victims through counseling, with equally beneficial consequences? Based on research in the use of cognitive therapy in other fields, the answer is likely to be, "yes".

Chapter V Footnotes

1. Chi square performed over all four crime categories (burglary, robbery, assault, and rape)=20.99, df=3, $p < .01$.

2. Chi sqaure performed over all three education categories (less than high school graduate; high school graduate; college graduate) = 13.77, df=2, $p < .01$.

3. Chi square performed over all three income categories (less than $10,000; $10,000-$20,000; $20,000 and over)=5.71; df=2,p=.06.

4. Chi square =7.58, df=1, $p < .01$.

5. Chi square =3.31, df=1, p=.07.

6. Tau C performed over all three income categories=0.09, p=.06.

7. Tau C performed over all three income categories=0.09, p=.06.

8. Tau C performed over all three age categories=0.12, p=.05.

9. Chi square performed over all three age categories=10.72, df=4, $p < .05$.

10. Because of the high correlation between the two self-blame items, (r=0.51), one was deleted from the multivariate analysis. The one included in the analysis is the item measuring behavioral self-blame.

VI. CONCLUSIONS

The findings of this study are consistent with the several other studies that have been done on the outcomes of counseling for crime victims. As in Smith and Cook's (1985) study, the vast majority of victims who received services believed that the services were helpful. In our study, that was especially true for victims who received cognitive restructuring instead of crisis counseling alone. But, while victims who received counseling showed improvement in measures of psychological distress three months later, improvement was equally great among victims who did not receive counseling; this finding agrees with the results of both Smith and Cook's work on crisis intervention and Kilpatrick's (1984) study of behavioral counseling with rape victims. Similarly, victims who received material assistance reported fewer practical adjustment problems three months later, but the decline in practical problems was no greater than among victims who did not receive such services.

The results of this and earlier studies do not mean that counseling crime victims is not useful. But if counseling does have effects, why have they been difficult to demonstrate empirically?

The probable answer to this question is that the treatment administered in this study and in Smith and Cook's study--consisting

usually of a single session of counseling--produced only weak and ephemeral effects. Any weak effects produced by counseling may well have been swamped by the healing effect of time. For most victims the crime does not produce such serious psychosocial disruptions that victims cannot cope themselves, and readjust over a period of days or weeks.

For other victims, there may be another reason why the effects of very brief counseling may be difficult to observe. We noted in Chapter 3 that at least some persons who become victims are already suffering from a myriad of economic, social, and psychological problems. For such individuals, using the concept of "crisis" to describe a single burglary, robbery, or assault may be inappropriate. Crisis intervention services focused only on a specific incident are unlikely to have measureable effects on psychosocial functioning when the victimization is a relatively minor part of a pattern of life stress.

For these reasons, it is likely that trying to measure effects of the very brief crisis counseling that most victims who request services avail themselves of would be unfruitful. It may have to suffice to know that victims consider it helpful to have someone listen sympathetically for an hour, lend some reassurance, and provide material aid that they might not otherwise get.

We believe that future research efforts on victim counseling are needed, but that they ought to focus on victims who usually require more extensive counseling. Research has shown that there are long-term effects of rape on sexual functioning and psychological well-being that often are not resolved completely with the passage of months, or even years. For rape victims (and perhaps also for victims of domestic violence, victims of assaults involving catastrophic injuries, and survivors of homicide victims), the concept of "crisis" seems to apply much better than to other victims. That is, rape victims suffer from a readily identifiable, stressful event that typically produces large disruptions in psychosocial functioning that are not readily ameliorated through the victim's normal coping mechanisms. For these victims, counseling has the potential to lessen the undesireable effects of crime that might otherwise remain at least partially unresolved. In other words, effects ought to be measureable. Moreover, victims are often willing to participate in a series of counseling sessions.

Within these parameters, there are a number of issues about <u>how</u> to counsel victims that deserve to be examined. Crisis counseling is based on a set of beliefs about how victims ought to cope with crises. Many of these beliefs have been borrowed from the brief psychotherapy model, which in turn, derives many of its assumptions from psychoanalytic theory (Aguilera and

Messick, 1978). But those beliefs are confused in several areas and are under challenge from new approaches and empirical evidence. For example, Lazarus (1983) argues for the psychodynamic view that victims' efforts to minimize their plight or focus on positive aspects of their situations are irrational attempts at denial. On the other hand, Taylor, et. al.'s (1983) theory of selective evaluation posits that, by focusing on positive aspects of their situations, victims facilitate their recovery. In fact, cognitive theorists would strongly encourage victims to do just that.

Cognitive-behavioral theorists would also encourage victims to work toward altering the underlying thoughts that give rise to them. On the other hand, the classic crisis intervention approach adopts the psychodynamic view that encouraging victims to "vent" their negative emotions is cathartic. The two views are very different: One posits that encouraging victims to express emotions releases negative energy and the other that doing so could reinforce a maladaptive thought pattern if left unchallenged.

Another area in which there are conflicting ideas is in dealing with the issue of heightened feelings of vulnerability that often follow victimization. Crisis counselors often attempt to reduce victims' feelings of vulnerability, and there is a good deal of theoretical literature in the field of coping which

argues that doing so should help victims to adapt (eg. Kirscht, et. al., 1966; Langer, 1975; LeJune and Alex, 1973). Moreover, research has consistently shown that control (or perceived control) over a situation - the opposite of vulnerability - plays an important role in reducing pathology in aversive situations (eg. Maier and Seligman, 1976; Kobasa, 1979). On the other hand, Perloff (1983) cites a substantial body of research which suggests that people who feel vulnerable to misfortune are more likely than those who feel invulnerable to engage in self-protective, preventive behaviors. Do attempts to ease victims' fears about vulnerability actually increase their risk of victimization?

Finally, the conventional view of "good coping" (eg. Bard and Sangrey, 1979) posits that it is harmful to victims to blame themselves for their misfortune. Self-blame is seen as perpetuating the falsehood that victimization is anything other than a chance event, and is seen as injurious to victims' self-concepts. Accordingly, victim counselors often discourage victims from blaming themselves. This position is in agreement with the view of several attribution theorists, including the revised learned helplessnes theory of Peterson and Seligman (1983). Their revised learned helplessness model argues that individuals who tend to attribute victimization to external, unstable, and specific causes (such as the bad luck to be in the wrong place at the

wrong time) are less likely to suffer distress than individuals who attribute their misfortune to internal, stable, and global causes.

On the other hand, Janoff-Bulman (1979) suggests that self-blame actually may be beneficial--if it is of the "behavioral" variety. If self-blame encourages victims to believe that they can control, through their actions, the risk of future victimization, Jannoff-Bulman argues that it may act to reduce distress. Her view is supported by empirical data from Baum, et al (1983), Friedman, et al (1982) and now from the present study as well, all of which found that behavioral self-blame does seem to reduce psychological distress in victims. Moreover, studies on attributional retraining reviewed by Forsterling (1985) show that encouraging people to believe that failures on tasks are due to lack of effort--a controllable behavior--improves persistence and subsequent performance. Does this mean that victims who blame the crime on their behaviors are more likely to engage in precautionary behavior than other victims? Data from this study not represented in this report sugggest that the answer is, "yes". What we do not know is whether victims who blame themselves are therefore less likely to suffer future victimizations.

Figure 6.1 casts the differing positions on the effects of self-blame in terms of Peterson and Seligman's dimensions of

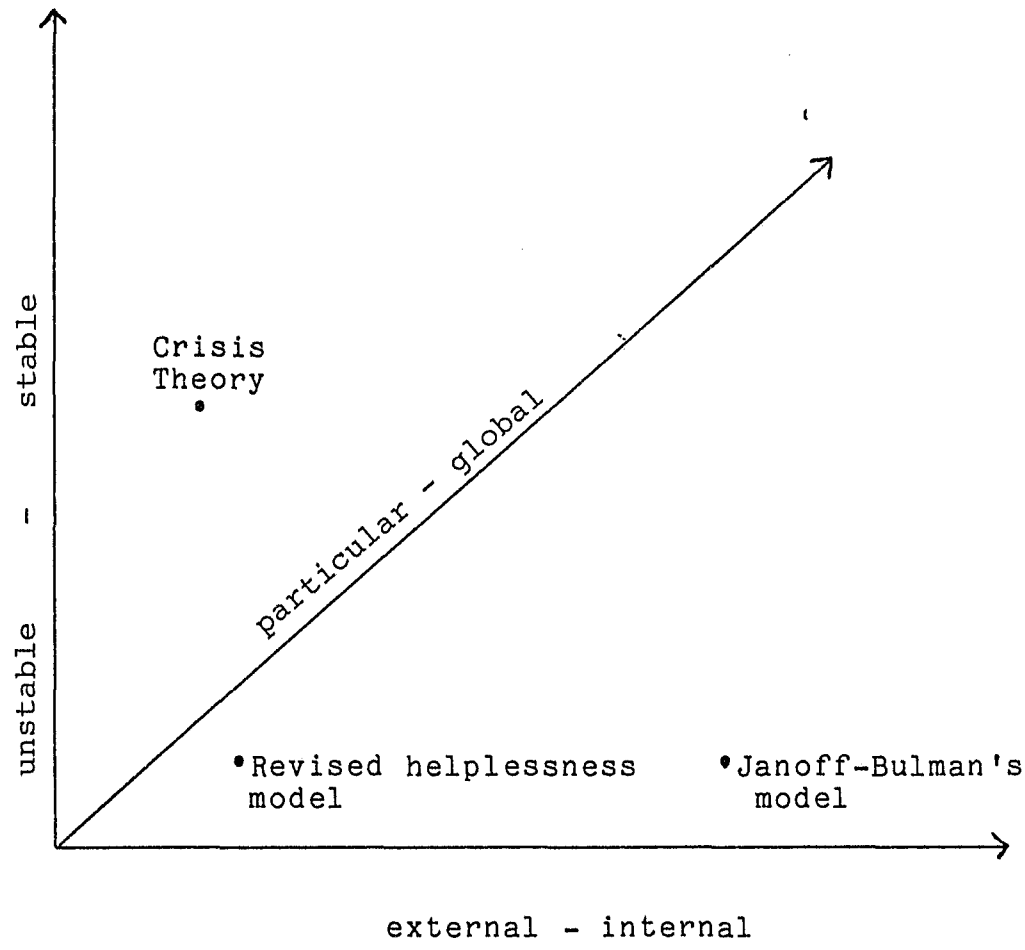


FIGURE 6.1: CONCEPTUALIZATION OF DIFFERENT APPROACHES TO VICTIM SELF-BLAME

internal-external, stable-unstable, and global-particular attributions of causality. Their revised learned helplessness theory argues that people ought to be encouraged to view the causes of victimization as unstable, particular, and external--in other words as uncontrollable bad luck. Crisis theory agrees with the revised learned helpless approach that people ought to be encouraged to view the cause of victimization as external, but not necessarily as unstable and particular as well. In contrast, Janoff-Bulman's approach argues that people should be encouraged to view the causes of victimization as unstable, particular, and internal rather than external--in other words as controllable. Her approach implies that counseling might include not only attributional retraining, but also training in risk-avoidance measures and other methods to encourage victims to think of victimization as controllable.

We believe that more research is needed on the effects of counseling upon victims of rape and other crimes which produce consequences that most victims cannot successfully cope with alone. We further believe that such monies would best be spent examining the implications that different assumptions about how to counsel victims have upon their psychosocial adjustment, risk-avoidance measures, and the likelihood of revictimization.

V.S.A. Study on the Effects of Counseling with Crime Victims

Read to Interviewee:

The Research Department of the Victim Services Agency is conducting this study to learn about the problems and needs of people who have been victimized by crime. This is your second interview and includes questions about it your reaction(s) to being a crime victim, and your ways of coping.

A major goal of this study has been to determine the type of services which are the most beneficial to meeting the needs of crime victims.

As you know, your participation is voluntary. You may refuse to answer any questions. Every interview will be treated in the strictest confidence, and a numerical coding system will be used instead of names. Your name will not appear on any information you share with us. Your cooperation is appreciated.

PART II: The Victimization

11. ☐ INTERVIEWER: CHECK HERE IF VICTIM REPORTED SEEING A COUNSELOR ON INITIAL INTERVIEW--Q 26.11.

IF BOX IS CHECKED, ASK:

The first time we talked, you said that you were seeing a counselor for problems related to the crime. Are you still seeing him/her?
Yes___ No___ Never saw one___

IF BOX IS NOT CHECKED ASK:
Have you seen a professional (counselor, social worker, psychologist) for problems you've experienced because of the crime?
Yes___ No___

|
|____ what kind of professional? _____

_____

FOR ALL VICTIMS, ASK:
What kind of help did you receive? _____

_____

_____

_____

12. Have you been a victim of a crime since your last interview with us.
Yes____ No_____

12a. What kind of crime? _____

12b. Please describe what happened.

_____

_____

_____

_____

16. INTERVIEWER: CHECK HERE IF VICTIM REPORTED PROBLEMS FROM CRIME ON FIRST INTERVIEW (Q 16 - Q21)

☐ MEDICAL BILLS

☐ PROPERTY LOSS/DAMAGE

☐ TROUBLE MAKING ENDS MEET

☐ LOST TIME FROM WORK

☐ Other (_____)

Last time we talked, you said that you had _____

(INTERVIEWER: FILL IN BASED ON ABOVE) as a result of the crime.

a. Do you still have this problem? (CHECK ALL THAT APPLY)

- ☐ Medical bills
- ☐ Property loss
- ☐ Trouble making ends meet
- ☐ Lost time from work
- ☐ Other
- ☐ N/A

b. Did anyone help you in resolving_____?
Yes___ No___ N/A___

- ☐ who? _____
  _____
- ☐ what did they do for you? _____
  _____
  _____

17. Were you provided with any of the following kinds of help (Check all that apply)

	Provided by VSA	Provided by other	Who
a. cash assistance	( )	( )	_____
b. referral for welfare emergency assistance	( )	( )	_____
c. Lock repair/replacement	( )	( )	_____
d. referral for free police security survey	( )	( )	_____
e. food coupons	( )	( )	_____
f. temporary place to stay	( )	( )	_____
g. money for transportation	( )	( )	_____
h. replacing credit cards, driver's license or other documents	( )	( )	_____
i. Crime Victims Compensation Board claim	( )	( )	_____
j. counseling	( )	( )	_____
k. assistance with getting your property returned	( )	( )	_____
l. information assistance with the courts or police	( )	( )	_____
m. referral for medical assistance	( )	( )	_____

n. other, what_____

_____

_____

17(a). If yes to any of the above,how helpful would you say this service was to you:

( ) extremely helpful

( ) somewhat helpful

( ) not so helpful

22. INTERVIEWER: MARK WITH A "1" ANY PRECAUTIONS MENTIONED ON Q 22 OF THE 1ST INTERVIEW. DO NOT ASK ANY SUCH ITEMS THIS TIME.

Since the first time we spoke, have you taken any of the following precautions (INTERVIEWER: MARK ANY POSITIVE ITEMS WITH A "2")

a. a new lock? ___
b. a burglar alarm? ___
c. a watchdog? ___
d. mace ___
e. a gun ___
f. self-defense course ___
g. a new phone number ___
h. storing valuables ___
i. not wearing jewelry on the street ___
j. joined a neighborhood anti-crime program ___
k. joined crime watch program ___
l. participated in Operation I.D. ___
m. request a Free Security Survey provided by the New York City Police Department ___
n. had you been the recipient of a free Security Survey of your premises before the crime ___
o. If yes to the above, did you comply with all of the recommendations made in the survey, some of the recommendations made in the survey, none of the recommendations made in the survey ___
p. Other, please specify: _____

_____

PART III: Coping Patterns

23. We know that being a victim of crime can be a very bad experience. But, are there any positive things that you can think of that resulted from your experience?

☐ Yes ☐ No ☐ D/K

What? _____

_____

_____

24. Since your experience as a crime victim do you feel any better or less able to handle yourself well in a crisis?

☐ No Change
☐ Better/able
☐ less able
☐ Don't know

In what way? _____

_____

_____

25. Has victimization changed the way you feel about yourself?

☐ No
☐ Yes _____ How? _____
☐ Don't know

_____

_____

32. Have you had any difficulty in the following areas since this experience?

	No Difficulty	a little Difficulty	a lot of Difficulty	Don't know Not Applicable
a) job performance.....	( )	( )	( )	( )
b) relating to spouse....	( )	( )	( )	( )
c) accomplishing daily chores.....	( )	( )	( )	( )
d) keeping appointments..	( )	( )	( )	( )
e) parenting.....	( )	( )	( )	( )
f) making decisions.....	( )	( )	( )	( )
g) relating to people at work.....	( )	( )	( )	( )
h) solving problems.....	( )	( )	( )	( )

33. Do you feel responsible in anyway for what happened?
Yes ___ No ___

34. Do you think there was something you could have done to prevent the crime?
1. Yes ___
2. No ___
3. If yes, what? _____

_____

35. Do you think the victimization has changed the way people look at you? Yes ___ No ___ If "Yes," in what way? _____

_____

_____

_____

_____

36. Since the first time we spoke, has anybody helped you deal with problems resulting from the crime? Yes ___ No ___

		Type of help
If "Yes," who?	(1) _____	_____
	(2) _____	_____
	(3) _____	_____
	(4) _____	_____
	(5) _____	_____

37. Since the first time we spoke, have you told anyone about the crime who has not been supportive? Yes ___ No ___
If "Yes," who? _____

_____

PART IV: Fear of Crime

26. As a result of the crime, are you doing any of the following? (Check those that apply).

___ 1. inviting someone over just so you would not have to be alone

___ 2. checking to see if anyone is following you on the street

___ 3. checking to see if anyone is hiding behind the front door or under the steps in the hallway to your apartment

___ 4. entering the apartment and checking to see if someone is hiding inside

39. Has the crime made you fearful of being in certain places or situations? Yes ___ No ___

___	what? _____
	_____
___	Have you been in any of these places since the crime? _____
	_____
___	What do (did) you think would happen if (when) you went there? _____
	_____

40. Has the crime made you afraid of certain types of people? Yes ___ No ___
If "Yes," what type of people? _____

_____

41. Since you were ( ) do you feel frightened or nervous in your home?
    1. no, not at all
    2. yes, somewhat
    3. yes, very much

42. Since you were ( ) do you feel frightened or nervous in your neighborhood?
    1. no, not at all
    2. yes, sometimes
    3. yes, often

43. Since you were ( ) do you go out alone at night?
    1. no, not at all
    2. yes, sometimes
    3. yes, often

44. Since you were ( ) do you go out alone during the day?
    1. no, not at all
    2. yes, sometimes
    3. yes, often

45. Have you moved since the crime?
    1. no
    2. yes
    If "no," would you like to move? Yes ___ No ___

46. Do you feel you have less control over your life?

    ___ a little ___ a lot ___ the same

    How likely is it that you will be a crime victim in the next year? _____

    _____

Part V: Self-Administered Instruments

48. Check the statements below that apply to you:

___1. What happened to me really, wasn't that bad compared to what some victims of crime go through.

___2. In a way, I was lucky things didn't turn out worse for me than they did.

___3. My experience as a victim changed the way I look at life. (How?)_____

_____

_____

_____

___4. My experience as a victim has changed the way I look at people (How?) _____

_____

_____

___5. Under the circumstances, I think I've handled things pretty well.

51. As a result of being a victim of a crime some people cope by becoming less involved in daily activities, while others become more involved. Please check the column which best describes your degree of involvement in the following activities.

	More Frequently than before the crime?	The Same	Less Frequently
Spending extra time on the job	____	____	____
Working on projects around the house	____	____	____
Cleaning the apartment	____	____	____
Listening to the radio	____	____	____
Watching television	____	____	____
Staying in bed	____	____	____
Sitting on the sofa	____	____	____
Smoking	____	____	____
Drinking	____	____	____
Daydreaming	____	____	____
Crying	____	____	____
Visiting friends, neighbors or relatives	____	____	____
Praying	____	____	____
Reading	____	____	____
Walking	____	____	____
Cooking	____	____	____
Shopping	____	____	____
Exercising	____	____	____
Using drugs	____	____	____

Psychological Scales
Revised Impact of Event Scale

Below is a list of comments made by people after stressful life events. Please check each item indicating how frequently these comments were true for you DURING THE PAST SEVEN DAYS. If they did not occur during that time, please mark the "not at all" column.

FREQUENCY

		Not at all	Rarely	Sometimes	Often
52.	I think about it when I don't mean to.				
53.	I avoid letting myself get upset when I think about it or am reminded of it.				
54.	I try to remove it from memory.				
55.	I have trouble falling asleep or staying asleep because of pictures or thoughts about it that come into my mind.				
56.	I have waves of strong feelings about it.				
57.	I have dreams about it				
58.	I stay away from reminders of it.				
59.	I feel as if it hasn't happened or it isn't real.				
60.	I try not to talk about it.				
61.	Pictures about it pop into my mind.				
62.	Other things keep making me think about it.				
63.	I am aware that I still have a lot of feelings about it, but I don't deal with them.				
64.	I try not to think about it.				
65.	Any reminder brings back memories of it.				
66.	My feelings about it are kind of numb.				
67.	I think about what I'd do with the person(s) that did it, if I had the chance.				
68.	I imagine going back to the scene of the crime and preventing the criminal from victimizing me.				

V.S.A. Study on the Effects of Counseling with Crime Victims

Read to Interviewee:

The Research Department of the Victim Services Agency is conducting a study to learn about victims's feelings, beliefs, and experiences. The interview includes questions about your background and daily activities, your reaction(s) to being a crime victim, and your ways of coping.

You have been selected (as a participant) to be part of a sample that will be representative of New York City Crime victims. The study will be useful in planning future counseling services for crime victims. A major goal of this study is to determine the type of counseling which will be the most beneficial to meeting the needs of crime victims.

As you know, your participation is voluntary. You may refuse to answer any questions. Every interview will be treated in the strictest confidence, and a numerical coding system will be used instead of names. Your name will not appear on any information you share with us. Your cooperation is appreciated.

NIJ Study Questionnaire

PART I: Background Information

1. How do you spend a typical day? _____

_____

_____

_____

_____

2. Prior to the crime were your activities different on a typical day than they are now? _____

_____

_____

_____

_____

3a. Do you live alone? Yes___ No ___

3b. If "No," who lives with you (write down relationships)?

_____

_____

_____

4. (Don't ask victims) Sex: Male ____ Female _____

5. What is your age (in years)? _____

6. What is your marital status? Single ___ Mar. ___ Wid. ___ Div. ___ Sep. ___

7. What is the highest grade of school you completed? _____

8. What is the main source of income for your household?

public assistance ___
unemployment compensation ___
disability ___
your job ___
spouse's job ___
combined income from both your job and spouse's job ___
other (please specify) ___

8a. What was the most recent job title of the main provider in your household? _____

9. What is your current annual household income?

0 - 4,999 ____	15,000 - 19,999 ____
5,000 - 9,999 ____	20,000 - 24,999 ____
10,000 - 14,999 ____	25,000 - 29,999 ____
	over 30,000 ____

10. (Don't ask victim) What is your racial background? Black ___ Hispanic ___ Caucasion ___ Native American ___ Other ___

11. Have you seen anyone during the past year for an emotional, nervous or mental problem? Yes ___ No ___
Who? _____

11a. Have you thought about hurting yourself during the past year? Yes ___ No ___ (If "Yes," to "thought about it," ask interviewee 11b)

11b. Please describe what happened _____

PART II: The Victimization

12. Please describe what actually happened during your victimization? _____

12a. How did you deal with it? _____

12b. Were you victimized in your neighborhood?
Yes ___ No ___

13. Were you present during the commission of the crime?
Yes ___ No ___ If "Yes," answer 13a and 13b.

13a. While the crime was being committed did you feel that your life was in danger? Yes ___ No ___

13b. Please describe what the criminal did that made you feel in danger? _____

14. Did you have any indication or feeling beforehand that something was not right? Yes ___ No ___

14a. If yes to the above, please describe what your feeling was. _____

_____

_____

_____

_____

15. Had you been a victim of a crime prior to this incident? Yes ___ No ___
a. If yes, how many times where you a victim? _____
b. When was the last time you were victimized? _____
c. Please describe what happened _____

_____

_____

_____

_____

16. As a result of the crime incident did you experience any of the following problems?

(1) physical injury? Yes ___ No ___
If Yes, what did (will) this cost you for medical expenses
$ _____

☐ Don't know

How much of the above medical costs were covered by insurance or a health plan? $ _____

☐ Don't know

(2) Property damage? Yes ___ No ___

If yes, about what did it cost you to repair/replace the property? $ _____

☐ Don't know

(3) Property loss? Yes ___ No ___

If yes, about what did (will) it cost to replace the property? $ _____

☐ Don't know

17. Has the crime affected your ability to make ends meet?
(1) Yes ___ (2) No___
If yes, how?_____

_____

18. Do you have any medical problems as a result of the crime?
(1) Yes ___ (2) No ___
If yes, please specify: _____

_____

_____

19. Has the crime limited your ability to go to work or perform your job? Yes___ No ___ N/A___
If yes, in what way _____

_____

(Record numbers of days lost from work or permanent loss of job, and circumstances if applicable)

_____

_____

_____

20. Did you quit your job? Yes ___ No ___ N/A___

21. Were there any other problems that you had as a result of the crime? Yes___ No ___ If yes, please describe _____

_____

_____

_____

_____

22. People use different things to protect themselves or their property from criminals. After the crime, did you take any of these precautions?

a.	a new lock?	(1) Yes ____	(2) No ____
b.	a burglar alarm?	(1) Yes ____	(2) No ____
c.	a watchdog?	(1) Yes ____	(2) No ____
d.	mace	(1) Yes ____	(2) No ____
e.	a gun	(1) Yes ____	(2) No ____
f.	self-defense course	(1) Yes ____	(2) No ____
g.	a new phone number	(1) Yes ____	(2) No ____
h.	storing valuables	(1) Yes ____	(2) No ____
i.	not wearing jewelry on the street	(1) Yes ____	(2) No ____
j.	joined a neighborhood anti-crime program	(1) Yes ____	(2) No ____
k.	joined crime watch program	(1) Yes ____	(2) No ____
l.	participated in Operation I.D.	(1) Yes ____	(2) No ____
m.	request a Free Security Survey provided by the New York City Police Department	(1) Yes ____	(2) No ____
n.	had you been the recipient of a free Security Survey of your premises before the crime	(1) Yes ____	(2) No ____
o.	If yes to the above, did you comply with <u>all</u> of the recommendations made in the survey,	(1) Yes ____	(2) No ____
	<u>some</u> of the recommendations made in the survey,	(1) Yes ____	(2) No ____

none of the recommendations made in the survey. (1) Yes ____ (2) No ____

p. Other, please specify: _____

_____

PART III: Coping Patterns

23. We know that being a victim of crime can be a very bad experience. But, are there any positive things that you can think of that resulted from your experience?

☐ Yes ☐ No ☐ D/K

What? _____

_____

_____

24. Since your experience as a crime victim do you feel any better or less able to handle yourself well in a crisis?

☐ No Change

☐ Better/able

☐ less able

☐ Don't know

In what way? _____

_____

_____

25. Has victimization changed the way you feel about yourself?

☐ No

☐ Yes _____ How? _____

☐ Don't know

_____

_____

26. As a result of the crime, are you doing any of the following? (Check those that apply).

___ 1. inviting someone over just so you would not have to be alone

___ 2. checking to see if anyone is following you on the street

___ 3. checking to see if anyone is hiding behind the front door or under the steps in the hallway to your apartment

___ 4. entering the apartment and checking to see if someone is hiding inside

___ 5. planning for a family outing or special activity

___ 6. joining a group to meet new people

___ 7. talking to a friend or family member about problem(s)

___ 8. finding a satisfying hobby you can do by yourself

___ 9. joining a sports team

___10. talking to a minister, priest, or rabbi

___11. talking to a professional counselor

28. Do you belong to a church or synagogue? Yes ___ No ___

28a. If "Yes", how frequently do you attend formalized religious activities?

___ Daily ___ Weekly ___ Monthly

___ Only on major holidays ___ Very rarely

29. After your victimization, did your participation in religious activities:

a) Increase a lot ___

b) Increase a little ___

c) Remain the same ___

d) Decrease a little ___

e) Decrease a lot ___

30. Why do you think your participation in formal religion has changed?

_____

_____

_____

32. Have you had any difficulty in the following areas since this experience?

	No Difficulty	a little Difficulty	a lot of Difficulty	Don't know Not Applicable
a) job performance.....	( )	( )	( )	( )
b) relating to spouse....	( )	( )	( )	( )
c) accomplishing daily chores.....	( )	( )	( )	( )
d) keeping appointments..	( )	( )	( )	( )
e) parenting.....	( )	( )	( )	( )
f) making decisions.....	( )	( )	( )	( )
g) relating to people at work.....	( )	( )	( )	( )
h) solving problems.....	( )	( )	( )	( )

33. Do you feel responsible in anyway for what happened?
Yes ___ No ___

34. Do you think there was something you could have done to prevent the crime?
1. Yes ___
2. No ___
3. If yes, what? _____

_____

35. Do you think the victimization has changed the way people look at you? Yes ___ No ___ If "Yes," in what way? _____

_____

_____

_____

_____

36. Has anybody helped you deal with problems resulting from the crime? Yes ___ No ___

		Type of help
If "Yes," who?	(1) _____	_____
	(2) _____	_____
	(3) _____	_____
	(4) _____	_____
	(5) _____	_____

37. Have you told anyone about the crime who has not been supportive? Yes ___ No ___
If "Yes," who? _____

_____

38. Is there anyone you feel you cannot talk to about the crime? Yes ___ No ___

If "Yes", who? _____

_____

PART IV: Fear of Crime

39. Has the crime made you fearful of being in certain places or situations? Yes ___ No ___

___ what? _____

_____

___ Have you been in any of these places since the crime? _____

_____

___ What do (did) you think would happen if (when) you went there? _____

_____

40. Has the crime made you afraid of certain types of people?
Yes ___ No ___
If "Yes," what type of people? _____

_____

41. Since you were ( ) do you feel frightened or nervous in your home?
    1. no, not at all
    2. yes, somewhat
    3. yes, very much

42. Since you were) do you feel frightened or nervous in your neighborhood?
    1. no, not at all
    2. yes, sometimes
    3. yes, often

43. Since you were) do you go out alone at night?
    1. no, not at all
    2. yes, sometimes
    3. yes, often

44. Since you were ( ) do you go out alone during the day?
    1. no, not at all
    2. yes, sometimes
    3. yes, often

45. Have you moved since the crime?
    1. no
    2. yes
    If "no," would you like to move? Yes ___ No ___

46. Do you feel you have less control over your life?

    ___ a little ___ a lot ___ the same

    How likely is it that you will be a crime victim in the next year? _____

    _____

Part V: Self-Administered Instruments

48. Check the statements below that apply to you:

___1. What happened to me really, wasn't that bad compared to what some victims of crime go through.

___2. In a way, I was lucky things didn't turn out worse for me than they did.

___3. My experience as a victim changed the way I look at life. (How?)_____

_____

_____

_____

___4. My experience as a victim has changed the way I look at people (How?) _____

_____

_____

5. Under the circumstances, I think I'm handling things pretty well.

51. As a result of being a victim of a crime some people cope by becoming less involved in daily activities, while others become more involved. Please check the column which best describes your degree of involvement in the following activities.

	More Frequently than before the crime?	The Same	Less Frequently
Spending extra time on the job	____	____	____
Working on projects around the house	____	____	____
Cleaning the apartment	____	____	____
Listening to the radio	____	____	____
Watching television	____	____	____
Staying in bed	____	____	____
Sitting on the sofa	____	____	____
Smoking	____	____	____
Drinking	____	____	____
Daydreaming	____	____	____
Crying	____	____	____
Visiting friends, neighbors or relatives	____	____	____
Praying	____	____	____
Reading	____	____	____
Walking	____	____	____
Cooking	____	____	____
Shopping	____	____	____
Exercising	____	____	____
Using drugs	____	____	____

Psychological Scales
Revised Impact of Event Scale

Below is a list of comments made by people after stressful life events. Please check each item indicating how frequently these comments were true for you DURING THE PAST SEVEN DAYS. If they did not occur during that time, please mark the "not at all" column.

		FREQUENCY			
		Not at all	Rarely	Sometimes	Often
52.	I think about it when I don't mean to.				
53.	I avoid letting myself get upset when I think about it or am reminded of it.				
54.	I try to remove it from memory.				
55.	I have trouble falling asleep or staying asleep because of pictures or thoughts about it that come into my mind.				
56.	I have waves of strong feelings about it.				
57.	I have dreams about it				
58.	I stay away from reminders of it.				
59.	I feel as if it hasn't happened or it isn't real.				
60.	I try not to talk about it.				
61.	Pictures about it pop into my mind.				
62.	Other things keep making me think about it.				
63.	I am aware that I still have a lot of feelings about it, but I don't deal with them.				
64.	I try not to think about it.				
65.	Any reminder brings back memories of it.				
66.	My feelings about it are kind of numb.				
67.	I think about what I'd do with the person(s) that did it, if I had the chance.				
68.	I imagine going back to the scene of the crime and preventing the criminal from victimizing me.				

Below is a list of of words that describe the way people sometimes feel. Indicate whether you have felt this way since the crime; never, rarely, sometimes, frequently, or always. Answer by circling the number in the column that best describes your mood.

	-0- never	-1- rarely	-2- sometimes	-3- frequently	-4- always
1. NERVOUS	0	1	2	3	4
2. SAD	0	1	2	3	4
3. REGRETFUL (sorry)	0	1	2	3	4
4. IRRITABLE (cranky)	0	1	2	3	4
5. HAPPY	0	1	2	3	4
6. PLEASED	0	1	2	3	4
7. EXCITED	0	1	2	3	4
8. PASSIONATE (sexual)	0	1	2	3	4
9. TIMID (bashful)	0	1	2	3	4
10. HOPELESS	0	1	2	3	4
11. BLAMEWORTHY	0	1	2	3	4
12. RESENTFUL (annoyed)	0	1	2	3	4
13. GLAD	0	1	2	3	4
14. CALM	0	1	2	3	4
15. ENERGETIC (lively)	0	1	2	3	4
16. LOVING	0	1	2	3	4
17. TENSE	0	1	2	3	4
18. WORTHLESS	0	1	2	3	4
19. ASHAMED	0	1	2	3	4
20. ANGRY	0	1	2	3	4
21. CHEERFUL	0	1	2	3	4
22. SATISFIED	0	1	2	3	4
23. ACTIVE	0	1	2	3	4
24. FRIENDLY	0	1	2	3	4
25. ANXIOUS (troubled)	0	1	2	3	4
26. MISERABLE (sad)	0	1	2	3	4
27. GUILTY	0	1	2	3	4
28. ENRAGED	0	1	2	3	4
29. DELIGHTED (pleased)	0	1	2	3	4
30. RELAXED	0	1	2	3	4
31. VIGOROUS (forceful)	0	1	2	3	4
32. AFFECTIONATE (tender	0	1	2	3	4
33. AFRAID	0	1	2	3	4
34. UNHAPPY	0	1	2	3	4
35. REMORSEFUL (sorry)	0	1	2	3	4
36. BITTER	0	1	2	3	4
37. JOYOUS	0	1	2	3	4
38. CONTENTED (satisfied	0	1	2	3	4
39. LIVELY	0	1	2	3	4
40. WARM	0	1	2	3	4

SCL-90-R

Name:_____ Technician:_____ Ident. No._____

Location:_____ Visit No.:_____ Mode: S-R_____ Nar_____

Age:_____ Sex: M_____ F_____ Date:_____ Remarks:_____

INSTRUCTIONS

Below is a list of problems and complaints that people sometimes have. Read each one carefully, and select one of the numbered descriptors that best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST_____INCLUDING TODAY. Place that number in the open block to the right of the problem. Do not skip any items, and print your number clearly. If you change your mind, erase your first number completely. Read the example below before beginning, and if you have any questions please ask the technician.

EXAMPLE

HOW MUCH WERE YOU DISTRESSED BY:

Descriptors
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

Answer

Ex. Body Aches..... Ex. [3]

HOW MUCH WERE YOU DISTRESSED BY:

Descriptors
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

1. Headaches.....
2. Nervousness or shakiness inside .....
3. Repeated unpleasant thoughts that won't leave your mind..
4. Faintness or dizziness.....
5. Loss of sexual interest or pleasure.....
6. Feeling critical of others .....
7. The idea that someone else can control your thoughts ....
8. Feeling others are to blame for most of your troubles.....
9. Trouble remembering things .....
10. Worried about sloppiness or carelessness .....
11. Feeling easily annoyed or irritated .....
12. Pains in heart or chest .....
13. Feeling afraid in open spaces or on the streets .....
14. Feeling low in energy or slowed down .....
15. Thoughts of ending your life.....
16. Hearing voices that other people do not hear .....
17. Trembling.....
18. Feeling that most people cannot be trusted .....
19. Poor appetite .....
20. Crying easily .....
21. Feeling shy or uneasy with the opposite sex.....
22. Feelings of being trapped or caught.....
23. Suddenly scared for no reason .....
24. Temper outbursts that you could not control.....
25. Feeling afraid to go out of your house alone.....
26. Blaming yourself for things .....
27. Pains in lower back .....
28. Feeling blocked in getting things done .....
29. Feeling lonely .....
30. Feeling blue .....
31. Worrying too much about things .....
32. Feeling no interest in things.....
33. Feeling fearful .....
34. Your feelings being easily hurt .....
35. Other people being aware of your private thoughts .....
36. Feeling others do not understand you or are unsympathetic .....
37. Feeling that people are unfriendly or dislike you.....
38. Having to do things very slowly to insure correctness ...
39. Heart pounding or racing.....
40. Nausea or upset stomach.....
41. Feeling inferior to others .....
42. Soreness of your muscles.....
43. Feeling that you are watched or talked about by others..
44. Trouble falling asleep .....
45. Having to check and doublecheck what you do .....
46. Difficulty making decisions .....
47. Feeling afraid to travel on buses, subways, or trains.....
48. Trouble getting your breath .....
49. Hot or cold spells .....
50. Having to avoid certain things, places, or activities because they frighten you .....
51. Your mind going blank .....
52. Numbness or tingling in parts of your body. .....

Appendix B

Inter-Item Correlations

TABLE B.1: Intercorrelations Among Fear of Crime Items

	Fear of Places/ Situations	Fear of Certain People	Fear in One's Home	Fear in One's Neighborhood	Fear of Going Out Alone At Night	Fear of Going Out Alone During the Day
Fear of Places/ Situations	1.00					
Fear of Certain People	.34	1.00				
Fear in One's Home	.24	.15	1.00			
Fear in One's Neighborhood	.34	.32	.37	1.00		
Fear of Going Out Alone At Night	.21	.11	.27	.11	1.00	
Fear of Going Out Alone During the Day	.17	.01	.21	.16	.41	1.00

TABLE B.2: Intercorrelations Among Behavioral Adjustment Items

	Job Performance	Relating to Spouse	Accomplishing Daily Chores	Keeping Appoint-ments	Parent-ing	Making Decision	Relating to People At Work	Solving Problems
Job Performance	1.00							
Relating to Spouse	.54	1.00						
Accomplishing Daily Chores	.67	.51	1.00					
Keeping Appointments	.45	.45	.54	1.00				
Parenting	.31	.47	.34	.38	1.00			
Making Decisions	.41	.36	.49	.41	.28	1.00		
Relating to People at Work	.51	.43	.29	.22	.46	.27	1.00	
Solving Problems	.48	.54	.58	.46	.36	.61	.45	1.00

TABLEB.3: Intercorrelations Among Self-Blame, "Selective Evaluation" and Life Control Questions

	Feel responsible for what happened?
Is there anything you could have done to prevent the crime?	0.51

(a) Self-Blame Items

	Comparison with others	Selective focusing	Could have been worse	Positive aspects	Coping well
Comparison with others	1.00				
Selective focusing	-0.13	1.00			
Could have been worse	0.16	-0.02	1.00		
Positive aspects	-0.06	0.21	0.08	1.00	
Coping well	0.29	0.07	0.12	0.14	1.00

(b) Selective Evaluation Items

(c) Life Control Items

	How likely is it you'll be a crime victim in the next year?
Do you feel less control over your life?	-0.06

TABLE B.4: INTERCORRELATIONS BETWEEN MEASURES OF PSYCHOLOGICAL DISTRESS AT THE INITIAL ASSESSMENT

	IES (Avoidance)	IES (Intrusion)	SCL-90R (GSI)	Fear of Crime	Behavioral Adjustment	ABS (Negative)	ABS (Positive)
IES (Avoidance)	1.00						
IES (Intrusion)	0.55	1.00					
SCL-90R (GSI)	0.48	0.65	1.00				
Fear of Crime	0.38	0.52	0.49	1.00			
Behavioral Adjustment	0.24	0.33	0.45	0.22	1.00		
ABS (Negative)	0.39	0.54	0.77	0.39	0.37	1.00	
ABS (Positive)	-0.05	-0.08	-0.12	-0.04	-0.08	-0.16	1.00

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