User Report

The Psychological Impact of Nonsexual Criminal Offenses on Victims

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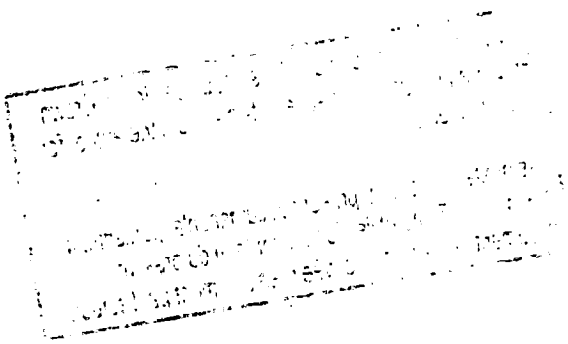

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Executive Summary

This report is a review of the psychological harm caused by "serious" non-sexual criminal offenses. It covers the crimes of robbery, nondomestic assault, domestic assault, physical child abuse, kidnapping and murder. A review of the psychological consequences of sexual offenses has already been conducted for the Solicitor General of Canada (see Hanson, 1989; contract No. 1512-HA01300-8901/824). This report is a continuation of that work.

In general terms, psychological reactions to stressful and traumatic life events like criminal victimization can range from "mild" to "severe". Mild reactions to stress are characterized by a wide range of symptoms including minor sleep disturbances, irritability, worry, interpersonal strain, attention lapses, and the exacerbation of prior health problems. Severe psychological harm, on the other hand, can be defined as the demonstration of symptomatology characteristic of the American Psychiatric Association's (APA) diagnostic criteria for Post Traumatic Stress Disorder (PTSD). According to the APA, the stressor capable of producing this syndrome is markedly distressing to almost anyone and outside the range of usual human experience. Symptomatology include 1) persistent heightened arousal (e.g., difficulties with concentration and memory, an inability to relax, impulsiveness, a tendency to be easily startled, difficulty falling or staying asleep, anxiety); 2) psychic numbing (e.g., depression, and a lack general responsiveness, disinterest in activities, estrangement from others, loss of interest in the future); and 3) recurring thoughts about the stressor (e.g., flashbacks or vivid and intrusive recollections, repeated nightmares, intense distress when exposed to similar situations).

Post Traumatic Stress Disorder may be acute, chronic, or delayed. It is believed to be more severe and longer lasting after a trauma caused by human design. The usual course is for symptoms to be strongest soon after the event and then diminish over time. Symptoms may worsen, however, when the individual is exposed to stimuli that resemble the original traumatic event.

The research literature indicates that psychological harm is not qualitatively dissimilar for victims of different criminal offenses, but rather is a matter of degree. In other words, although the psychological sequelae experienced by victims of sexual assault, robbery, burglary, and kidnapping vary in intensity, the nature of their distress is similar. A general model of factors relevant to victim recovery is, therefore, proposed. The model posits that reactions to criminal victimization are mediated by three classes of variables, ordered in time: 1) victims' pre-victimization characteristics, 2) victims's post-victimization abilities to cope, and 3) factors related to the criminal event (see Figure 1). Although the research that has been conducted on moderators has been limited, the available evidence suggests that these three groups of factors are integral to our understanding of the consequences of criminal victimization.

Many Canadians are victimized every year by robbery. The crime is usually marked by violence and loss of property. The psychological sequelae range from mild upset and anger to post-traumatic stress disorder. Virtually every victim experiences some emotional and/or

behaviourial reaction and approximately 10-30% of robbery victims suffer "severe" short-term trauma. After six months the effects appear to diminish. However, between 5-10% of victims continue to suffer significant psychopathology.

Research has shown that as a result of being robbed, women generally suffer more than men, and the elderly experience more distress than the young. Prior health problems compound the subsequent distress whereas an established social support network can buffer negative psychological consequences. It appears that threats of violence and the use of a weapon may also exacerbate the trauma of robbery. The data is equivocal with regard to the effectiveness of behaviourial coping such as staying at home more often or moving residences. Robbery victims who receive supportive help tend to get over the negative effects more readily. Finally, repeated victimization compounds the psychological distress experienced by victims of this criminal offense.

A serious limitation of much of the assault research is that few empirical studies differentiate physical assault victims from those of domestic violence. It is therefore difficult to know whether by including female domestic violence victims in their samples, the studies inflate (or deflate) the negative effects of assault on victims. Thus, the statements made in this summary regarding both nondomestic assault and domestic assault should be considered tentative.

Short-term psychological reactions to nondomestic assault experienced by roughly 40% of victims include anger, difficulty sleeping, uneasiness, confusion, bewilderment, denial, fear and shivering. More serious reactions including depression, helplessness, loss of appetite, nausea and malaise are reported by 20-40% of victims. Most of these effects persist for up to three weeks. Three to six weeks later approximately 15% of victims feel "very much" affected and about 5% have life-long reactions to this criminal offense.

Moderators of the effects of assaults have not been extensively researched. Most of the available evidence suggests that women, severely beaten victims, victims who engage in avoidance related behaviours, and victims not receiving support from others may be particularly at risk for developing subsequent psychological problems.

Statistics indicate that many women are subjected to domestic violence by their partners. Although domestic violence is a common problem, it often goes unrecognized by professionals. The psychological reactions of battered women are characteristic of post traumatic stress disorder. The sequelae resemble those experienced by rape victims but often last over a longer period (i.e., the attacks frequently recur over many years). Anxiety and depression, increased fears and phobias, recurring nightmares, sleep and eating disorders, disturbed affect, problems with interpersonal relationships and repeated intrusive recollections of the traumatic event are common. Somatoform disorders, drug abuse and suicidal behaviour have also been reported. Children who are raised in homes with domestic violence are also at risk for developing psychological and behaviourial problems.

Little empirical research has been conducted on moderator variables of domestic violence. Childhood experiences with abuse, the duration and severity of the assaultive behaviour, behavioural responses such as staying at home more often, poor social support, and the negative response of victim service agencies and law enforcement personnel have all been shown to influence the psychological impact of domestic violence.

All indications are that physical child abuse is more pervasive than official statistics show. Given the methodological inconsistencies in this literature, in addition to the various definitions of abuse, a concise integration of the research findings is difficult. The best available evidence indicates that, compared to nonabused children, child victims of physical assault have several psychosocial problems including noncompliance, tantrums and aggression directed towards both other children and adults. They also have problems with peer relationships, possess social skills deficits, have less empathy, and adjust and achieve poorly in school. Aggression, low self-esteem, cognitive deficits, and behavioural disorders are some of the more serious consequences. Data are not available on the number of physically abused children who develop these problems.

Research of the long-term psychological sequelae associated with physical child abuse is sparse. It is, however, reasonable to assume that the long-term implications can be significant. Serious intellectual deficits, language delays, interpersonal problems, affective and behavioural disturbances resulting from childhood physical abuse all are likely to interfere with adaptive functioning later in life.

Although the research is limited, it appears that physical assaults resulting in serious injury, abuse beginning at an early age, and assaultive behaviour lasting over a long period are related to more severe psychological distress. Some children have been shown to be more resilient to the consequences of physical abuse than others. Early intervention by child protection agencies is perhaps the best way to avert long-term psychological sequelae.

The psychological sequelae of acts of anti-state terrorism like kidnapping and hostage taking, are not as severe as state conducted terrorism, but, nonetheless, are significant. Short-term psychological effects reported by hostage victims include poor concentration, intrusive thoughts and nervousness, fear, depression and rage. A minority of these victims continue to suffer from long-term distress ranging from sleep disturbance and memory problems to post traumatic stress disorder. The impact of child abduction may be more serious and long-lasting because of the violation of trust that is involved. Some studies have shown that abducted children develop psychological problems, including symptoms of PTSD, that increase rather than decrease in severity as time passes.

The research on moderator variables is also limited. With regard to both state and anti-state terrorism, it appears that the longer and more violent the victimization experience, the worse the psychological reactions. Young children who are kidnapped are particularly susceptible. Social support and treatment intervention may also be important moderators to the longer-term consequences of these offenses. It is unclear what effect, if any, the development of the "Stockholm Syndrome" during hostage-taking situations has on subsequent outcomes.

Although murder is a relatively uncommon criminal offense, its effects can be severe for the surviving family members. The psychological symptomatology is consistent with post traumatic stress disorder and is experienced by the vast majority of survivors. Approximately three-quarters develop the disorder following the violent loss of a significant other. The effects can be expected to last for several years. With regard to moderator variables, not enough research has been conducted to make many conclusive statements.

Clearly a great deal more research attention needs to be directed at the behavioural and psychological consequences of criminal victimization. The pool of knowledge about the effects of sexual offenses has grown significantly over the last twenty years but relatively little attention has been paid to the victims of crime discussed here. Based on current information, we know that the distress caused by these offenses can be severe. However, even less is known about the effects of other criminal code offenses such as arson. Battered women, survivor victims of homicide, victims of kidnapping, hostage-taking and children who are physically beaten by their caregivers all have been shown to experience symptoms characteristic of post traumatic stress disorder. Many robbery and assault victims also reportedly experience many of these symptoms. A minority can expect to receive the diagnosis. The long-term consequences can also be severe if intervention and treatment are not provided.

Great progress in research has been made, but our understanding of what constitutes a serious offense from the perspective of the victim remains limited. Even in the absence of this information one can still conclude that every criminal code offense has potentially severe consequences on victims depending on pre-victimization factors, characteristics of the offense, and post-victimization factors outlined in the model.

Preamble

This manuscript was prepared under contract from the Canadian Ministry of the Solicitor General. A literature search revealed that very little has been published on the psychological impact of non-sexual crimes as listed in the Parole Act (or Schedule I to the Corrections and Conditional Release Act). Therefore, this report focuses on the psychological effects of physical assault (including domestic violence and child physical abuse), robbery and kidnapping on victims as well as the effects of "secondary" victimization on the survivors of homicide. Under these topic headings reference will be made to the "serious harm" offenses of a non-sexual nature listed in the Parole Act (e.g., "causing injury with intent", "assaulting a police officer"). However, this final report will not review the effects of the Parole Act offenses *per se*. Unfortunately, there was insufficient literature to justify reviewing the offenses of "arson" and "prison breach".

Notably missing from the Parole Act offenses is "breaking and entering". Although the literature on effects of this crime is not specifically reviewed here, reference to its impact is made when discussing the comparative impact of criminal offenses on victims. A summary of the findings can be found at the end of each section of this report.

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Introduction

A criminal offense is not only a violation of law, but frequently harm is also inflicted on a victim. Indeed, it has been argued that crime by definition necessitates that there be a victim (Hough, 1985; Schafer, 1977). The victim may be a person, an organization, or society. Invariably, someone or something will be endangered, harmed, or destroyed when a criminal act is perpetrated.

Historically, the victim has been studied by criminologists as an integral component in the process of crime causation and control (Von Hentig, 1948; Wolfgang, 1958). Victims were viewed as "complementary partners" with offenders, shaping and moulding their criminal behaviour. Wolfgang (1958), for example, saw homicide and aggravated assault as "victim-precipitated" crimes in which the victim initiated insults and/or physical force against an individual who responded accordingly.

The tendency of individuals to attribute responsibility to victims for their misfortune has been addressed by Ryan (1971; 1974) and Lerner (1970; 1974). They theorized that people have a strong need to believe that their environment is a just and orderly place where people get what they deserve. To maintain this belief in a fair and just world, individuals look upon others who are affected by a social problem as different in some way than themselves - perhaps less competent, less skilled, less knowledgeable, strange, etc.. They contended that we cannot easily accept the unsettling prospect that our social system is faulty so we are compelled to believe that victims are the architects of their own destiny. People therefore will attempt to derogate victims, perceiving them as the sort of people deserving misfortune.

Over the last twenty years (circa, 1970), researchers have shifted their focus from one of being primarily interested in how victim attributes precipitate the commission of criminal acts to an interest in victimization rates (Komesar, 1973), victim demographics, (e.g., Conklin & Bittner, 1973), the reporting of crime (e.g., Smith & Maness, 1976), fear of crime (e.g., Garofalo, 1979), and the costs of criminal victimization (e.g., Pope, 1977). In addition, victimologists have recognized that there is very little known about effects of victimization apart from the economic losses (Parsonage, 1979). Less understood are the social psychological costs associated with criminal victimization - such losses are less tangible.

Once labelled the "forgotten persons" in the criminal justice system, victims and their problems have become the focus of considerable attention. To a large extent, current interest in the effects of criminal acts grew out of the feminist movement of the early 1970s. Women became increasingly vocal about their experiences with and reactions to sexual assault and domestic violence (Baril, 1984; Resick, 1987b). As a result, public awareness of the frequency with which women are the targets of violence grew (Sales, Baum & Shore, 1984). Centres offering assistance to these women emerged and by the mid-1970s governments began funding grants for research. At this time, Hough (1985) contends an

evergrowing scepticism existed among individuals working in the criminal justice system about its ability to deter or rehabilitate those who pass through it. Millions were being spent to apprehend, prosecute, incarcerate, and rehabilitate offenders, yet the needs and wishes of victims went unheard. In the context of this scepticism, victim service agencies were established and effectively lobbied to have their interest in the plight of the crime victim placed on the political agenda. Subsequently, governments allocated significant resources to fund victim assistance programs and increase our understanding of the problems suffered by victims of crime.

Research conducted over the last decade has revealed that many individuals endure a wide range of psychological problems varying in intensity and duration as a direct result of criminal victimization. The current literature clearly indicates that the aspects commonly thought of as most unsettling (i.e., physical injury and/or the loss of property) may be less important than the psychological trauma experienced by victims of crime (APA, 1985; Bard & Sangrey, 1986). Among the most grievous and long lasting injuries are generally perceived as being those at the level of feeling and behaviour. The consensus among researchers and service providers is that criminal victimization produces a variety of psychological and behavioural disruptions ranging from short-term relatively minor discomfort to serious long-term post traumatic stress disorder (APA, 1985; Bard & Sangrey, 1986; Burgess & Holmstrom, 1979; Kilpatrick, Saunders, Veronen, Best & Von, 1987; Maguire, 1980; Walker, 1985; Wirtz & Harrell, 1987b).[1]

The purpose of the current paper is to review the range and severity of psychological effects that many nonsexual offenses have on victims and identify the factors that mediate the degree of harm experienced. The effects of robbery, kidnapping, physical assault (including domestic violence and child physical abuse) on victims as well as the effects of homicide on surviving family members will be addressed. However, it is first necessary to discuss the limitations of the more general criminal victimology literature. These limitations reduce the confidence one can place in the conclusions regarding the consequences crime has on its victims.

Limitations of the literature

It is a generally accepted fact that victims of crime suffer. However, the precise nature of the trauma caused by the offense, the intrapsychic processes involved, the influence of moderator variables, and several other important issues remain the subjects of debate. Part of the problem stems from the fact that researchers working in the field of victimology operate from diverse academic perspectives. For example, social psychologists studying reactions to stress, negative outcomes and victimization have focused primarily on the assumptions, attributions, and perceptions that influence (or are influenced by) the psychological and behavioural responses to distress, personal failure and/or loss of control. Other psychologists, usually those with clinical training, have concentrated their efforts on the emotional trauma that may accompany unpredictable and sudden negative life-events.

Many are also interested in the social support received by crime victims, the quality of service provided by victim assistance agencies, and the effectiveness of treatment strategies. Unfortunately, the theory and research findings of researchers and practioners working in these various fields of psychology have seldom borrowed from or melded with the wealth of data on victimization accumulated by criminologists. Referring to the literature on rape, Burt and Katz (1985) were struck by "how completely individual writers have narrowly focused on their own particular perspective without regard for the wider context" (p. 327).

Perhaps the most serious problem with the victimization research is that it has been primarily phenomenon-orientated, exploratory, not theory driven. Few attempts have been made by researchers to articulate the process by which symptomatology occurs. Although it is true that many phenomenological studies have provided valuable descriptions of the behaviour of interest, this approach rarely generates abstract formulations from which hypotheses can be made (Burt & Katz, 1985; Peterson & Seligman, 1983). Conversely, purely theoretical conceptualizations have been proposed that fail to integrate the existing empirical findings. For example, models have been proposed that negate the impact of criminal victimization is mitigated by a series of interlinked antecedent, concomitant, and consequential events and cognitions.

A phenomenon-oriented approach to the study of victimization has also resulted in a research literature split into discrete areas (Peterson & Seligman, 1983). Researchers studying the effects of crime have frequently chosen to investigate a particular group of victims without considering the implications of their findings with respect to other crime victims. In addition, the vast majority of psychological research has concentrated on victims of sexual assault rather than on any other type of crime. Janoff-Bulman and Frieze (1983) observed that this bias extends towards studying female victims despite the type of crime investigated. Indeed, many people "tend to think of the prototypic victim as female" (p. 8).

Beyond these theoretical concerns, several methodological shortcomings should be considered when evaluating the victimology literature. Burt and Katz (1985) have identified several problems with the methods employed to study the effects of sexual assault that are also frequently found in the research on robbery, domestic violence, burglary and other crimes. First, commonly researchers do not use standardized instruments to assess reactions in terms of depression, anxiety, and other symptoms. Open-ended questions and those tailored to suit specific researchers limit generalizability and often make cross-study comparisons difficult. When standardized instruments are used, they are usually customized in some manner, perhaps for use over the telephone or shortened in length. It is rare when the psychometric properties of these modified questionnaires are reported.

Second, problems are present with the sampling procedures. Although there are some notable exceptions, many studies have relatively small sample sizes (e.g., 10-25 subjects), occasionally consisting of a single case. In addition, victims are usually selected by placing advertisements in newspapers, chosen from police files or identified by their presence in a victim crisis program. These methods of subject selection sample only from the ranks of

people seeking assistance. For example, a significant number of crime victims do not report the offense to the police. In Canada, it is estimated that only 32% of robbery offenses are brought to their attention (Sacco & Johnson, 1990). Therefore, research findings based on a sample of these victims selected exclusively from police files will only be representative of a narrow subset of the total population of robbery victims.

Finally, nonvictim control groups are rarely used and, if they are selected, they are often chosen using different recruitment methods. Seldom are nonvictims screened to determine if they have been recently victimized and studies conducted with clinical samples frequently draw control groups from other clinical populations. These sampling techniques may result in a miscalculation of the type and degree of symptomology experienced by crime victims.

In sum, the sampling procedures commonly found in the victimology literature are such that the findings of individual studies may not be generalizable to the entire population of crime victims, or occasionally, even to other victims of the same kind of offense. However, despite its many methodological and conceptual shortcomings, it is appropriate to conclude that the existing literature on the impact of criminal victimization has succeeded in providing a detailed and valuable picture of the multiple psychological, behavioural, physical and material costs of crime. In particular, research on the effects of sexual assault has provided a wealth of valuable information about the general process of criminal victimization. Unfortunately, the literature on the effects of other crimes (in particular arson and kidnapping) has been comparatively sparse.

It has been argued elsewhere (Markesteyn, 1991) that a broader view of the victimization process is needed; one that integrates the findings from the various areas of victimology into a general model predictive of victim reactions to crime. The next section will present a selected summary of this model. The model will provide a framework within which to evaluate the psychological effects of crime in general and more specifically, the consequences of physical assault, domestic violence, physical child abuse, kidnapping, robbery and homicide.

Model of victim reactions to crime

Some considerations

As previously discussed, over the last fifteen or twenty years a substantial number of empirical studies have been conducted that have increased our understanding about the cognitive and functional processes of criminal victimization. However, considering the profound personal impact crime can have on individuals (see Bard & Sangrey, 1986) and the apparent complexities of this event, the combined pool of knowledge about the consequences of crime and the processes involved is small.

Moreover, the victimology literature has, for the most part, been fragmented. The research data and theoretical formulations of researchers working in a variety of fields and disciplines have not been previously amalgamated. Various aspects of the victimization process have been explored without the direction of an overriding theoretical model. Alternately, purely theoretical conceptualizations have been made that fail to integrate existing data.

There are, of course, some important limitations to the use of models predictive of behaviour (Janoff-Bulman & Frieze, 1983; Sales et al., 1984). First, a general model of victimization response will not predict individual outcomes. For example, people commonly differ in terms of prior life events and in terms of their abilities to cope with personal tragedy. These factors may influence the psychological responses of most victims but may be of less importance than, for instance, the degree of violence experienced by a particular individual. Second, one must be careful not to presume that the conclusions regarding the victims of one type of crime are generalizable to another without corroborative empirical support. Victimization studies commonly group a broad spectrum of victim types without attempting to differentiate, for example, armed robbery from pursesnatching. However, a more common error found in the victimization literature has been "to assume the uniqueness of patterns derived from a single victim group when such patterns actually characterize a broader set of victim reactions" (Sales et al., 1984, pp. 130-131). Citing the works of Krupnick and Horowitz (1980), Bard and Sangrey (1986), and Silver and Wortman (1980), Sales et al. (1984) concluded that the research on reactions to specific crises "may be more generalizeable than was previously thought" (p. 131) and, particularly relevant to this discussion, "studies that span different victim groups seem to find more similarity than difference" (p. 131). In other words, the reactions of victims subjected to different crimes may be qualitatively similar. Support for this position is extensive and integral to the concept of a general model of victim reaction.

Variations in reactions by offense

In general terms, the relationship between type of crime and subsequent reactions is straight forward; the more "serious" the offense, the more serious are the psychological effects on the victim. Theoretically, this relationship is reflected in Bard and Ellison's (1974) hypothesis that a victim's psychological distress is a function of the intrusiveness (i.e., degree of personal violation) they experience. Accordingly, in so far as people regard their homes as symbolic extensions of themselves, Bard and Ellison postulate a burglary can induce a crisis of "the self". A more serious violation involving loss of control and personal autonomy may occur when a person is robbed and, moving up the scale, robbery plus personal assault invokes a double threat, both loss of control and injury to the body (the "envelope" of the self). Finally, the most serious crime, other than homicide, generally producing the most extreme personal violation, that of the "inner self", is forcible rape.

However, Bard is also careful to point out that "although the injury to the self intensifies as the crime becomes more serious, the degree of violation experienced by an

individual victim finally depends on the meaning of the crime in that person's life. What seems a minor incident to one victim may be a personal catastrophe for another" (Bard & Sangrey, 1986, p. 17). For example, the experience of being robbed by gunpoint may potentially represent a more intense violation than being sexually assaulted, depending on the individual involved.

The Bard-Ellison hypothesis has been tested in two ways. First, researchers have studied the relationship between the degree of violence that is inherent in different types of crime and subsequent psychological trauma. This work has concentrated on factors related to the severity and intrusiveness of criminal events such as weapon use, physical injury, relationship with offender, and number of assailants. Generally, the research indicates that the greater the *overall* degree of violence, regardless of the particular type of offense, the more severe and long-lasting the psychological distress is for the victim (Briere & Runtz, 1988; Conte & Schuerman, 1987; Cook, Smith & Harrell, 1987; Ellis, Atkeson & Calhoun, 1981; Kilpatrick, Saunders, Amick-McMullan, Best, Veronen & Resick, 1989; Norris & Feldman-Summers, 1981; Sales et al., 1984; Smale & Spickenheuer, 1979; Waller & Okihiro, 1978).

Second, researchers have compared the effects that different types of criminal offenses have on victim reactions. The impact of sexual assault, for example, has been compared to the impact of robbery, burglary, etc.. A substantial body of literature has been published on this topic (Bourque, Brumback, Krug & Richardson, 1978; Brown & Yantzi, 1980; Cook et al., 1987; Fields, 1980; Friedman, Bischoff, Davis & Person, 1982; Frieze, Hymer & Greenberg, 1987; Greenberg, Ruback & Westcott, 1983; Hanson, 1989; Kilpatrick et al, 1985; Kilpatrick, Saunders, Veronen, Best & Von, 1987; Kilpatrick et al., 1989; Krupnick & Horowitz, 1980; Lurigio, 1987; Maguire & Corbett, 1987; Norris, Kaniasty & Scheer, 1990; Resick, 1987b; Noyes & Slymen, 1979; Shapland, Willmore & Duff, 1985; Symonds, 1980a, 1982; Wirtz & Harrell, 1987a, 1987b, 1987c). Although studies occasionally report data to the contrary, the consensus in the literature is that victims of "serious" crimes involving an aspect of physical assault suffer more psychological distress than victims of other crimes. In particular, the conclusion most frequently reached by those who have reviewed the literature is that female victims of completed sexual assault experience the most trauma.[2]

Another research finding commonly reported is that victims of different crimes experience many of the same mental health problems. Qualitatively similar effects have been found by researchers comparing the impact of rape, physical assault, robbery, and burglary. Cook et al. (1987), for example, compared the impact of sexual assault, domestic assault, nondomestic assault, robbery and burglary and reported evidence that "criminal victimization causes a generalized psychological reaction that is common to most victims regardless of the crime" (p. 13). Not surprisingly, the type of crime had a considerable influence on the level of victim distress but the differences between the groups were determined to be a matter of *degree* rather than *type*. Wirtz and Harrell (1987a) subjected these data to further analysis and concluded "it would appear that response to victimization is a more unified psychological

process than is typically reported in the literature. While differences (other than level) in response patterns between victims of different types of crime remain to be discovered, there appears to be a fair degree of communality in the way in which victims, as a group, respond to their victimization" (p. 275). Other researchers have also noted a similarity of victim responses to different crimes (e.g., ABA, 1983; Fields, 1980; Frieze et al., 1987; Greenberg et al., 1983; Kilpatrick et al., 1985; Krupnick & Horowitz, 1980; Lurigio, 1987; Resick, 1987a, 1987b; Shepherd, Qureshi, Preston & Levers, 1990).

Theoretically, the similarity of victim reactions can be accounted for by "crisis theory" (see Bard & Ellison, 1974; Bard & Sangrey, 1986; Beigel & Berren, 1985; Burgess & Holmstrom, 1974; Caplan, 1964; Flynn, 1989; Lindemann, 1944; Paap, 1981; Shepherd, 1990; Sutherland & Scherl, 1970; Symonds, 1980a, 1982; Waller, 1984). Caplan (1964) defines a crisis as "a relatively short period of psychological disequilibrium in a person who confronts a hazardous circumstance that for him constitutes an important problem which he can for the time being neither escape nor solve with his customary problem solving resources" (p. 23). Crisis theorists argue that the sudden and unpredictable nature of criminal victimization can produce such intense stress that the victim frequently finds it difficult to cope. According to Bard and Sangrey (1986), the crisis evoked by this event threatens "the self" which in turn produces significant disruption in the emotions and behaviour of the threatened person.

Lindemann (1944), who is considered by many to be the "father" of modern crisis theory, studied the victims and families of the famous Coconut Grove nightclub fire in Boston and observed that immediately following a crisis many victims display acute "grief" which is remarkably uniform in symptomology. Crisis reactions subsequently reported in the literature include feelings of tiredness, depression, exhaustion, helplessness, frustration, inadequacy, anxiety, shock, confusion, a range of physical symptoms and disorganized interpersonal functioning (see Bourque et al., 1978; Ellison & Buckhout, 1981; Halpern, 1973). Furthermore, Lindemann (1944) observed that when faced with a crisis, people's reactions have a regular pattern; one that tends to occur in stages. Bard and Sangrey (1986) integrated much of the earlier work and created a generic description of the crisis stages through which most crime victims pass. They suggest that the three stages (impact, recoil and reorganization) "serve as a broad outline on which victims can overlay their own unique experience" (p. 35).

In sum, the literature indicates that, independent of the offense, victims of crime experience similar kinds of reactions. The psychological effects of sexual assault, physical assault, robbery, burglary, and kidnapping vary in intensity, but share many features. Although victims of sexual assault suffer greater distress than victims of robbery and burglary, the nature of their psychological distress is qualitatively similar. Given that criminal victimization has qualitatively comparable effects, it is plausible that a similar constellation of variables act as potential moderators of the degree of trauma experienced by all victims of crime. To this end, Markesteyn (1991) has reviewed the victimology literature and proposed a general model of factors relevant to victim recovery.

The Model

Markesteyn's model is based on the earlier work of Sales et al. (1984) who developed a paradigm to account for the reactions of female victims of sexual assault. As previously discussed, studies comparing the psychological and behavioural consequences of different crimes on victims have indicated that there are qualitatively comparable effects of victimization. Markesteyn (1991) therefore reasoned that Sales and her colleagues' model may have general applications for victims of other offenses.

In their article Sales et al. noted that there was very little information published on factors affecting victim reactions to crime. Subsequently a great deal of additional research on the processes involved in (and consequences of) criminal victimization has been conducted. In retrospect, the elements of Sales et al.'s original conceptualizations have remained fundamentally sound but the theoretical formulations and empirical data of others suggest a more complex model of crime victim adaptation and recovery.

Markesteyn (1991) reviewed the published theory and empirical data of victimology researchers from a variety of disciplines and generated a model of factors predictive of short and long-term victim psychological reactions to crime (see Figure 1). The model includes variables which researchers and service providers in a variety of disciplines (e.g., social work, medicine, psychology and criminology) have shown to be associated with (1) victims' pre-victimization characteristics, (2) victims' post-victimization abilities to cope, and (3) factors related to the criminal event. These three sequential "classes" of variables span the period from before the crime to months, even years, following the victimization. In the model, each set of factors may influence later variables, as well as the overall outcome. For example, the impact of crime on a victim may be influenced by the reactions of law enforcement personnel, which in turn may be influenced by the degree of violence associated with the offense, which in turn may be related to demographics.

Pre-victimization Factors. The first set of variables refer to relatively stable aspects of a crime victim's life that affect his or her ability to cope. First, research has shown that several demographic variables are predictive of victim reactions following crime. Although the data base is small and consistent results are not always found, most available evidence indicates that socioeconomic status variables (e.g., income, occupation, education), gender and age are important predisposing factors. Compared to those less fortunate, victims with more education, better jobs and (generally as a consequence) higher incomes demonstrate the strongest ability to recover from victimization (Atkeson, Calhoun, Resick & Ellis, 1982; Burgess & Holmstrom, 1978a; Brown & Yantzi, 1980; Cook et al., 1978; Cook et al., 1987; Friedman et al., 1982; Koss & Koss, 1991; Maguire, 1980; Maguire & Corbett, 1987; Smale & Spickenheuer, 1979).

The research has also been consistent in showing that female victims suffer more than men (Bourque et al., 1978; Elias, 1986; Hough, 1985; Leymann, 1985; Maguire, 1980; Maguire & Corbett, 1987; Markesteyn, 1987; Wirtz & Harrell, 1987b), at least in the short-

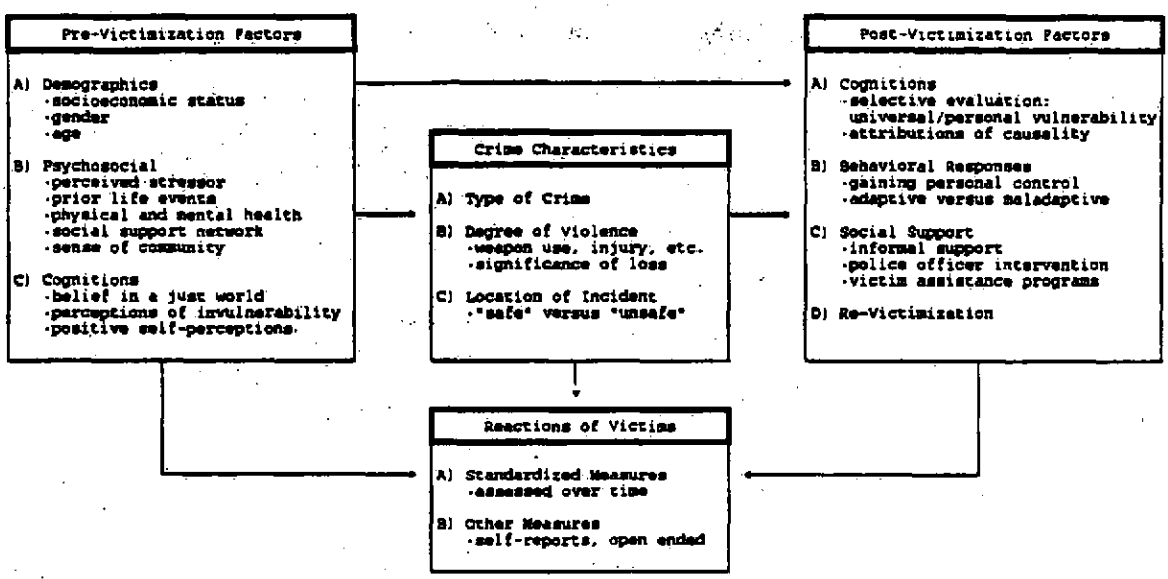

Figure 1. Model of Factors Relevant to Victim Recovery

term (e.g., Cook et al., 1987; Resick, 1987b), and that the elderly experience worse economic, psychological, physical and social effects than younger victims, not including children (Atkeson et al., 1982; Clemente & Kleinman, 1976; Conklin, 1976; Deluty & Quay, 1984; Elias, 1986; Eve, 1985; Faletti, McClelland, Quay & Johnson, 1981; Feinberg, 1981; Frank & Stewart, 1984; Kilpatrick et al., 1985; O'Brien, Shichor & Decker, 1982/1983; Ruch & Chandler, 1983; Sales et al., 1984). Regarding the elderly, some studies have either failed to find a positive correlation between age and adverse reactions (Bourque et al., 1978;

Brown & Yantzi, 1980; Friedman et al., 1982; Gabor, Baril, Carson, Elie, LeBlanc & Normandeau, 1987; Kilpatrick et al., 1987) or have found that younger victims suffer more than adults (Burnham, Stein, Golding, Siegal, Sorenson, Forsythe & Telles, 1988; Cook et al., 1987; Fields, 1980; Flynn, 1989; Kilpatrick et al., 1989; Sales et al., 1984). These findings have led to suggestions that the exacerbated impact of crime on older victims can be attributed to their impoverishment and powerlessness, both of which are common among the very old and very young rather than on chronology *per se* (Bard & Sangrey, 1986; Cook et al., 1978; Cunningham, 1976; Maguire & Corbett, 1987).

The few studies that have looked at religious denomination (Atkeson et al., 1982; Bourque et al., 1978; Cook et al., 1978; Ruch & Chandler, 1983; Wirtz & Harrell, 1987b) have found it is not predictive of outcomes. In addition, only two studies have revealed any relation between a victim's race and subsequent symptomatology (Friedman et al., 1982; Ruch & Chandler, 1983).

Along with demographics, the psychosocial literature has provided evidence that victims' prior experiences dealing with stress (including previous victimization), their pre-existing physical and mental health, social support resources, and sense of community with others in their neighbourhood can significantly influence the recovery process. Prior life stressors can either strengthen and bolster a person's ability to cope with later losses or be disabilitating and disrupt future coping ability, particularly if the prior stress has not been satisfactorily resolved (Caplan, 1964). Research indicates that the influence of prior stressors on victims' abilities to cope vary depending on the stressors' perceived significance, severity, longevity and relationship with other life events (Bourque et al., 1978; Burgess & Holmstrom, 1978a, 1978b; Cook et al., 1987; Fields, 1982; Koss & Koss, 1991; Markesteyn, 1987; McMurray, 1988; Resick, 1987b; Ruch, Chandler & Harter, 1980; Ruch & Chandler, 1983; Sales et al., 1984; Singleton & Teahan, 1978; Sprang, McNeil & Wright, 1989; Tinklenberg, 1982; Walker, 1985).

Retrospective analysis of victims' lives has also revealed that a connection exists between the effects of victimization and pre-victimization physical and psychological health (Atkeson et al., 1982; Biles, Braithwaite & Braithwaite, 1979; Burgess & Holmstrom, 1978a; Gabor et al., 1987; Hilberman & Munson, 1978; Koss & Koss, 1991; Krupnick & Horowitz, 1980; Ruch & Chandler, 1983; Sales et al., 1984; Silver & Wortman, 1980; Symonds, 1980b; Terr, 1983). It appears that, for some people, daily struggles with chronic health and social problems may overly tax coping ability, thus depleting reserve energies and ultimately leaving them more vulnerable to the adverse effects of negative life events.

Other pre-victimization psychosocial variables that appear to moderate post-crime outcomes are (a) the quality and availability of supportive relationships and (b) sense of community. Emphasis in the victimization literature is usually placed on the supportive actions of others following a crime rather than the value of prior support, so this topic receives special attention under the "post-victimization factors" heading in the model. Community psychologists have produced some empirical evidence suggesting that people who

experience a strong sense of community and neighbourhood bonds are less afraid of crime, independent of actual crime rates (Cohn, 1978; Riger, LeBailly & Gordon, 1981), and that physical proximity is an important attribute of people who help crime victims (Friedman et al., 1982; Mrazek & Mrazek, 1987).

Third, the social psychological literature has led to predictions about the role that individuals' pre-victimization cognitions play in determining their reactions to crime. According to social psychological theory, the psychological toll exacted by a victimizing event can best be understood in terms of the assumptions and beliefs we generally hold about ourselves and the world we live in. It is the shattering, or loss, of these assumptions and beliefs that generate negative reactions to crime (Bard & Sangrey, 1986; Janoff-Bulman, 1985; Janoff-Bulman & Frieze, 1983; Wortman, 1983; Wortman, Abley, Holland, Silver & Janoff-Bulman, 1980; Symonds, 1975). Specifically, it has been suggested that individuals' beliefs in a "just world" (Lerner, 1970; 1971; Lerner & Matthews, 1967; Lerner & Miller, 1978; Lerner & Simmons, 1966), perceptions of personal invulnerability (Janoff-Bulman & Frieze, 1983; Janoff-Bulman, Madden & Timko, 1983; Lejeune & Alex, 1973; Perloff, 1983; Reiser & Geiger, 1984; Wortman, 1983) and positive self-perceptions (Coates & Winston, 1983; Janoff-Bulman, 1985; Janoff-Bulman & Frieze, 1983) influence post-victimization reactions to crime.

Crime Characteristics. The second set of variables that can affect victims' reactions are the characteristics of the crime itself. As previously discussed, it is generally agreed that all types of criminal victimization can be distressing for victims. The most traumatic offenses are usually sexual, followed by nonsexual assault, robbery and property crimes (Hanson, 1989). However, researchers who have compared the reactions of victims to different crimes and other traumatic events have also found remarkable similarity in these reactions (ABA, 1983; Cook et al., 1987; Fields, 1980; Frieze et al., 1987; Greenberg et al., 1983; Kilpatrick et al., 1985; Krupnick & Horowitz, 1980; Lurigio, 1987; Markesteyn, 1986; Resick, 1987a; 1987b; Wirtz & Harrell, 1987a). Differences between groups have been shown to be more a matter of *degree* rather than *type*.

Although the empirical evidence has not reliably shown that specific characteristics related to a crime's violence (e.g., weapon use, injury incurred, etc.) are predictive of subsequent psychological trauma, there is substantial data indicating a positive relationship between the *overall* degree of violence associated with a criminal offense and the severity of distress later experienced by victims (Agopian, 1984; Allodi, 1989; Briere & Runtz, 1988; Brown & Harris, 1989; Conte & Schuerman, 1987; Cook et al., 1987; Ellis et al., 1981; Kilpatrick et al., 1989; Koss, Koss & Woodruff, 1991; Mullen, Romans-Clarkson, Walton & Herbison, 1988; Norris & Feldman-Summers, 1981; Norris, Kaniasty & Scheer, 1990; Sales et al., 1984; Smale & Spickenheuer, 1979; Waller & Okihiro, 1978).

The location of the offense also may be related to outcomes. Victims who are attacked in an environment they perceived as being "safe" (such as their homes), have been shown to suffer more negative reactions than those attacked in "unsafe" locations (Frank &

Stewart, 1984; Scheppele & Bart, 1983). This finding may account for the extreme trauma experienced by some burglary victims (Brown & Harris, 1989; Maguire, 1980; Markesteyn, 1991).

Post-Victimization Factors. Researchers and practioners have suggested that several coping mechanisms are available to crime victims that, if utilized, can lessen the psychological impact of their misfortune. The coping strategies employed by victims of crime are often varied and complex. The literature indicates that they may draw upon a combination of their own resources as well as the social support and professional assistance of others.

First, Taylor, Wood and Lichtman (1983) have theorized that victims can eliminate or at least minimize the extent of their misfortune by evaluating themselves and/or their misfortune against selected standards of comparison. Similarly, Perloff (1983) has suggested that victim coping may depend on whether the experience of being victimized leaves one feeling "uniquely vulnerable" or "universally vulnerable". Research has shown that recent crime victims report feeling highly vulnerable to future victimization (Burgess & Holmstrom, 1974; Friedman et al., 1982; Greenberg et al., 1983; Lanza, 1983; Lejeune & Alex, 1973; Lurigio, 1987; Medea & Thompson, 1974; Tyler, 1980). Data also exist showing that victims who perceive themselves uniquely (as opposed to universally) at risk experience more psychological sequelae (Hill & Zautra, 1989).

A victim's ability to cope with the consequences of crime also depends on other cognitive processes. One of the most important moderators of the impact of crime, or any negative life event, is an individual's causal attributions (see Abramson, Seligman & Teasdale, 1978; Bard & Sangrey, 1986; Janoff-Bulman, 1979; Seligman, 1975; Shapiro, 1989; Weiner, 1972, 1985). Seligman and his associates suggest that if crime victims have learned to perceive the cause of their misfortune as internal, stable and global they are likely to experience depressive reactions and/or loss of self-esteem typical of a learned helplessness response (Burns & Seligman, 1989). Although empirical support for the concept of an attribution style is equivocal (Bagby, Atkinson, Dickens & Gavin, 1990; Cutrona, Russell & Jones, 1984), some writers have used Seligman's theory to account for the negative reactions of some crime victims (Blair, 1986; Elias, 1986; Walker, 1978, 1985).

More commonly, victimization researchers examining the role of attributions have employed the theoretical postulates of Wortman (Wortman, 1976; Wortman & Brehm, 1975) and Janoff-Bulman (Janoff-Bulman, 1979, 1982, 1985; Bulman & Wortman, 1977). Although self-blame is perceived by many researchers and health providers as maladaptive (e.g., Beck, 1967), Wortman and Janoff-Bulman have argued that the self-blame commonly engaged in by crime victims can be adaptive and reflect a desire to regain some control over their lives. Moreover, Janoff-Bulman has postulated that victims who engage in adaptive self-blame are attributing the cause to some action or behaviour that is modifiable. Only victims who attribute the cause of their misfortune to their character experience low self-esteem, depression and the other deficits usually associated with criminal victimization. Unfortunately, data supporting Janoff-Bulman's theory have only come from samples of

college students (Janoff-Bulman, 1979, 1982; Peterson, Schwartz & Seligman, 1981) or hospital patients (Bulman & Wortman, 1977; Chodoff, Friedman & Hamburg, 1964; Timko & Janoff-Bulman, 1985). There are some exceptions (Friedman et al., 1982; Hill & Zautra, 1989), but overall empirical data gathered on "real" victims of crime have not corroborated these findings (Frazier, 1990; Gold, 1986; Markesteyn, 1986; Meyer & Taylor, 1986; Miller & Porter, 1983).

Finally, Weiner's (1972; 1985) attribution theory has been forwarded as having particular relevance for crime victims. According to Weiner, depending on whether an event is perceived as favourable or unfavourable, it will lead to either a positive or negative emotional response, which he called an attribution independent emotion. Individuals then engage in a search for causal understanding along three dimensions to answer the question "Why?". Causal ascriptions are examined in terms of their locus, stability, and controllability. The emotional reactions reported by many crime victims, for example, including low self-esteem, anger, guilt, shame, and helplessness, are postulated to arise because of attributions made to internal, stable, uncontrollable causes (see Brown & Weiner, 1984; Weiner, 1985; Weiner, Graham & Chandler, 1982). Again, although Weiner's theory of attribution has received substantial empirical support, it has not been directly tested with a population of actual crime victims. Still, of the three attributional theories briefly reviewed here, it may prove to be particularly relevant to the understanding of postvictimization psychological reactions to crime (Markesteyn, 1991).

In addition to the cognitive mechanisms employed by crime victims, behavioural coping strategies have proven to be a potentially effective means of dealing with victimization. Tyler (1980; 1981) has suggested that behavioural reactions to the threat of criminal victimization are strongly related to perceptions of personal control. Direct actions taken by victims following a crime can provide them with a sense of control over their environment and, in so doing, reduce feelings of vulnerability, inequity and helplessness (Frieze et al., 1987; Janoff-Bulman & Frieze, 1983; Maguire, 1980). The range of security related behaviours engaged in by victims of crime has been well documented (cf. Burgess & Holmstrom, 1979b; Burt & Katz, 1985; Cohn, 1974; Conklin, 1972; Lejeune & Alex, 1973; Lavrakas, 1981; Lurigio, 1987; Maguire, 1980; Reppetto, 1974; Sacco & Johnson, 1990; Shapland et al., 1985; Scheppele & Bart, 1983; Waller & Okihiro, 1978). However, Wirtz and Harrell (1987b) have shown that some behavioural responses may not only fail to facilitate recovery but may be counter adaptive. Specifically, although more research is needed, there is some evidence which suggests that "avoidance-oriented" behaviour (see Billings & Moos, 1981; Burt & Katz, 1985; Fattah & Sacco, 1989) such as not interacting with others or refusing to venture outdoors are more likely to be related with short-term psychological distress and prolonged feelings of vulnerability than are constructive, active coping strategies like improving security measures (Burgess & Holmstrom, 1979b; Friedman et al., 1982; Skogan & Maxfield, 1981, Wirtz & Harrell, 1987d).

The availability and effectiveness of the social support crime victims receive from others is another important post-victimization factor related to coping ability. Victims

seeking emotional support and/or other forms of assistance may turn to relatives, friends, or neighbours, as well as law enforcement officers, medical, legal or mental health professionals. The empirical data and theoretical arguments extolling the benefits of the support these people can provide victims of crime are extensive (Agopian, 1984; Atkeson et al., 1982; Bard & Sangrey, 1986; Burgess, 1975; Burgess & Holmstrom, 1978a; Coates & Winston, 1983; Cobb, 1976; Fattah & Sacco, 1989; Friedman et al., 1982; Frieze et al., 1987; Gold, 1986; Ruch & Chandler, 1983; Sales et al., 1984; Silver & Wortman, 1980; Stekette & Foa, 1987). Almost without exception (Cook et al., 1987), the research has demonstrated a correlation between the positive support people receive and their ability to adapt to and successfully overcome stressful life events.

In the realm of social support law enforcement and victim services intervention are particularly crucial. Although less than 50% of all crimes are reported the police (Sacco & Johnson, 1990; Solicitor General, 1984), these professionals are frequently the first officials with whom victims come in contact (Waller, 1984). The literature strongly suggests that depending on its quality, the support provided by the police and other victim assistance personnel, including those who work in the criminal justice system, can either facilitate or impede the ability of victims to overcome their ordeal (A.P.A., 1984, 1985; Bard & Sangrey, 1986; Bourque et al., 1978; Brown, 1970; Brown & Harris, 1989; Brown & Yantzi, 1980; Burgess & Holmstrom, 1975; 1978b; Cook et al., 1987; Davis, 1987; Feinberg, 1981; Finn & Lee, 1985; Friedman et al., 1982; Gottfredson, Resier & Tsegaye-Spates, 1987; Harris et al., 1984; Hough, 1984; Maguire, 1980; 1984; Kennedy & Homant 1983; 1984; Kidd & Chayet, 1984; Krupnick & Horowitz, 1980; Lee & Rosenthal, 1983; Norris et al., 1990; Resick, 1987b; Rodino, 1985; Rosenbaum, 1987; Sales et al., 1984; Shapland et al., 1985; Shepherd, 1990; Symonds, 1980; Waller, 1985; Wirtz & Harrell, 1987c; Zlotnick, 1979).

Finally, "re-victimization" may influence crime victim reactions. Fear of re-victimization and retaliation by offenders has been shown to be a major concern for burglary, assault and robbery victims (Friedman et al., 1982; Shapland et al., 1985). Statistics indicate that one-third of property offense victims and one-quarter of victims of personal crime have previously experienced the same incident (Conklin, 1972; Solicitor General, 1988). This is a particular concern for victims of domestic violence and child abuse because they are subjected to repeated violent episodes that commonly occur over a period of years. The compounded effects of multiple victimization over time have been shown to cause serious psychological and behaviour related problems (Cohen & Roth, 1987; Friedrich, Urquiza & Beilke, 1986; Leymann, 1985; Mullen , Romans-Clarkson, Walton & Herbison, 1988; Normandeau, 1981; Norris et al., 1990; Resick, 1987b; Walker, 1978, 1985).

Discussion will now turn to the short and long-term psychological effects of robbery, kidnapping, physical assault (including child abuse and domestic violence), and homicide. The general model of victim reactions to crime outlined above will serve as a guide to the possible moderator variables that can mitigate the impact of these offenses.

Before proceeding, the reader is advised to review the limitations of the research mentioned earlier in this report. It bears repeating that a great deal more empirical research needs to be conducted before conclusive statements regarding the impact of many criminal offenses can be made. While some general comments can be made regarding the impact of the crimes to be discussed, reliable and valid estimates of the proportion of victims who will experience "severe" consequences are very difficult to make.

Robbery

Statistics

Results of the Canadian Urban Victimization Survey indicate that for the year 1982, the incident rate for robbery in urban centres was 10 per 1000 for people 16 years and older (Himelfarb, 1984). The rate was 13 per 1000 for males and 7 per 1000 for females. In the seven Canadian cities surveyed 49,200 incidents of robbery were recorded. By 1988, the rate of robbery in Canada (both urban and rural) had risen to 13 per 1,000 among people 15 years or older (Sacco & Johnson, 1990). That rate translated into approximately 265,000 robberies.

Between 50% and 68% of all robbery offenses are not reported to the police (Scanlon, 1982; Sacco & Johnson, 1990; Solicitor General, 1984). Australian statistics show that in 1975 there were approximately 14,200 robbery offenses involving an aspect of violence (Biles et al., 1979). By comparison, 74% of the robberies and/or attempt robberies recorded in Canada in 1988 involved an aspect of physical violence (Sacco & Johnson, 1990). A weapon was present in 28% of robberies and 68% were committed by an offender acting alone. A surprisingly large percentage occurred in the victim's own residence (32%). In the United States, F.B.I. data indicate that robbery is the stranger to stranger crime that most frequently results in victim death and injury (Zimring & Zuehl, 1986).

National Crime Survey (NCS) data collected the United States from 1973 to 1979 indicated that 60% of all robberies resulted in property loss. The median dollar loss was $30.00 (Block, 1989). Canadian statistics reveal that 50-56% of all robbery/attempt incidents result in a loss of money (Himelfarb, 1984; Sacco & Johnson, 1990). The mean net loss in 1982 dollars was $176.00 (Himelfarb, 1984). British data indicate that 75% of robbery and "snatch theft" victims had property less than £25 stolen (Hough & Mayhew, 1985). As one might expect, there is considerable variation in the amount lost by the type of robbery. From the perpetrators perspective, the least profitable crimes are taxi hold-ups and pursesnatchings (Conklin, 1972).

Short and long-term psychological effects

Bard and Ellison (1974) describe the impact of robbery in terms of a violation of the "self". In contrast to burglary where the victim is not directly involved, not only are personal possessions taken, but the victim is forcibly deprived of his or her independence and

autonomy; in other words, the ability to determine one's own fate. The threat of violence and loss of control over one's fate can have a profound ego impact. If a robbery victim is assaulted or a weapon is involved the effects will even be worse (Bard & Sangrey, 1986). When this occurs the "envelope of the self" is injured and victims are left with a physical reminder of the fact that they were forced to surrender their autonomy and were unable to protect themselves. Bard and Ellison (1974) go on to suggest that robbery, and in effect, all crimes against the person will precipitate crisis reactions in victims that seriously compromise their abilities to cope or function (also see Bard & Sangrey, 1986).

Scientific data on the extent and nature of crisis in robbery victims are scarce. Bourque et al. (1978) reported the results of an unpublished dissertation on robbery by Syvrud (1967). Syvrud sent questionnaires to 218 victims and found that 2-37% of the respondents had immediate and extreme psycho-physical reactions after being robbed. Victims most commonly reported feeling a sense of helplessness but these reactions were relatively short-lived. Roughly one-third of those surveyed claimed they were over the effects of being robbed almost immediately following their initial shock and approximately 85% had returned to a normal life after one month.

One of the most thorough studies on the effects of robbery has been conducted by Resick (1987a). She tracked the reactions of male and female and robbery victims from one to 18 months after the offense. Victims were assessed in terms of overall distress (Global Severity Index score, GSI), overall self-esteem (Tennessee Self-Concept Scale score, TSCS), fear (Modified Fear Survey, MFS), depression (Beck Depression Inventory, BDI), and cognitive elements of post-traumatic stress disorder (Impact of Event Scale, IESTOT)(see Table 1). Resick found considerable adjustment problems in robbery victims on all of the assessment measures. Moreover, many of the clinical problems reported by the victims lasted the entire 18 months.

Gabor et al. (1982) studied the psychological impact of armed robbery on a sample of 111 victims working in the Montreal area and reported that over 90% of respondents mentioned they underwent some type of emotional and/or attitudinal change after the offense (also see Normandeau, 1981). Approximately three-quarters of the victims said that the incident made them feel more distrustful of others or that they feared another hold-up. Twenty-five percent stated they had become more aggressive. Other notable reactions included frequent changes in mood (13.7%), generalized fear (13.2%) and depression (9.9%). While the physical effects of armed robbery were found to disappear within a few weeks, 68% of the victims reported they were experiencing psychological effects more than six months after the crime occurred. When asked what they considered the most noteworthy event or experience resulting from the hold-up, mistrust and feelings of fear, anger and vulnerability dominated.

Similar findings have been reported in England. Results of the British Crime Survey revealed that 35% of robbery victims felt that fear, worry, nervousness, health problems, stress and/or upset were *the worst problems* faced because of the incident (Hough &

Table 1.
Percentage of robbery victims in Resick (1987a) exhibiting mental health problems over time †

clinical measure	1 month		3 months		6 months		12 months		18 months	
	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀
GSI	31	31	21	10	22	12	15	16	21	10
BDI	1	8	3	4	2	5	5	5	3	-
TSCS	5	3	4	6	10	9	5	4	7	7
MFS	-	13	1	6	-	8	-	8	2	7
IESTOT	17	34	5	12	6	5	5	8	9	10

† at two standard deviations above the mean

Mayhew, 1985). Fifty one percent of those surveyed said that they had experienced no emotional problems after being robbed. Of the remaining 49%, 28% mentioned fear, worry and/or loss of confidence, 13% said they felt upset, 8% indicated they experienced depression, stress, sleeping, and/or health problems, and 1% reported feeling angry, frustrated and/or annoyed.

Results of another British study conducted by Maguire and Corbett (1987) corroborated many of these findings. Forty percent of victims who reported the offense to the police said they were "very badly affected" by the robbery. In the first few days after the event they experienced many of the same reactions reported by Hough and Mayhew (1985) as well as anger, uneasiness, confusion, shock, vulnerability, listlessness, headaches, and loss of strength. Unfortunately, for many of their analyses Maguire and Corbett combined their sample of robbery and assault victims, thus making interpretations difficult.

Bourque et al. (1978) interviewed 44 victims of robbery selected from three cities in the United States and reported that 21% of their sample manifested extreme physical upset, memory loss or residual effects after the offense. Generalizing these results to the population, they estimated that between 10 and 15 percent of all robbery victims experience serious psychological trauma. Furthermore, they also found that the greater the immediate crisis victims experienced, the longer the impact lasted.

Kilpatrick et al. (1985) conducted telephone interviews with 65 women who were robbed and reported that almost 8% of their sample had a nervous breakdown, 11% had contemplated suicide and 3%, had attempted to take their life. Unfortunately the nature of their study's design made it impossible to ascertain whether these psychological problems were a direct result of being robbed or were present before the offense occurred. Addressing this problem, Kilpatrick et al. (1987) conducted follow-up interviews with these women and assessed them for lifetime prevalence versus current prevalence of post traumatic stress disorder (PTSD). They were able to determine that 18.2% of female robbery victims developed PTSD at the time of the offense and that 9.2% were experiencing symptoms indicative of this diagnosis on average 7.8 years later.

One of the most extensive studies of robbery has been conducted in Sweden. Over the course of 4 years Leymann (1985) surveyed approximately 221 bank employees who were involved in 73 robberies in the Greater Stockholm area. He tracked the reactions of victims over a six month period and found a variety of stress symptoms were exhibited at varying times (see Table 2). Stress symptoms were most frequently reported immediately after the robbery, the rest of the day and the following night. The reaction most commonly mentioned immediately after the robbery was insomnia followed by difficulty concentrating and feelings of insecurity. While most symptoms disappeared quickly, feelings of insecurity were reported by over 10% of victims as long as six months after the attack. Overall, it was estimated that between five and eight percent of victims showed long-term psychological effects. These data were later factor analyzed by Leymann (1988) and seven distinct stress reaction profiles emerged. The psychological responses of bank robbery victims were found to fall into one of the following clusters: (1) psychosomatic gastrointestinal reactions, (2) severe psychosomatic reactions, (3) depression-like preoccupation, (4) insomnia, (5) adrenaline reactions, (6) depression reactions and (7) compulsive reactions.

The Norwegian research on bank robbery has been summarized by Weisaeth (1985) who reported that 20-23% of victims developed sufficient symptoms of PTSD to require treatment. Like Leymann (1985), Weisaeth stated that long-term problems are rarely reported by bank robbery victims.

Finally, research conducted in Australia has revealed that almost six times more robbery victims describe their mental health or nervous condition as poor rather than good (Biles et al., 1979). These data should be interpreted with caution however as it was impossible to determine whether the mental health problems were as a result of the robbery or existed before the offense occurred.

Moderator variables

Pre-victimization factors. Resick (1987a) compared the reactions of male and female robbery victims over time and found that there were significant differences on a few of the measures one month after the offense. Specifically, women tended to become more depressed and exhibit more post-traumatic stress disorder symptoms than men. However, beyond the first

Table 2.
Percentage of bank robbery victims in Leymann (1985) reporting stress symptoms †

symptoms	during robbery	after robbery	within 3 weeks	within 6 months	after 6 months	before robbery
headaches	2.7	13.2	8.2	6.4	6.4	11.0
difficulty concentrating	13.2	34.2	18.7	6.4	5.0	1.8
insomnia	-	40.6	21.5	5.0	4.1	4.1
sleep disturbances	-	19.6	18.7	8.7	5.9	3.2
nightmares	-	13.2	18.7	12.8	9.6	4.6
shaky hands	25.1	19.2	4.1	2.7	1.4	1.4
lump throat	14.2	7.8	2.3	0.9	0.5	0.5
weak legs	25.6	18.3	1.4	0.5	0.5	0.9
dry mouth	13.7	6.4	1.8	0.5	0.5	0.9
heart palpitations	40.6	12.3	1.4	0.5	0.9	1.8
despondency	1.8	16.4	12.3	6.4	5.0	1.4
listless	7.3	11.0	3.2	2.3	0.9	1.4
weeping	1.8	13.2	6.8	2.7	0.9	0.9
fear	16.9	17.4	15.5	9.1	8.2	3.2
restlessness	0.5	11.0	5.5	1.8	1.4	0.9
insecurity	14.2	23.7	24.2	13.7	11.4	6.4

† table only shows symptoms reported by at least 10% of the bank employees at any time

month, most of these differences disappeared or could be accounted for by preexisting gender differences. Bourque et al. (1978) reported that female robbery victims were more likely to have a crisis reaction than men. Women were also found to exhibit more stress related symptoms after being robbed by Leymann (1985) and Maguire and Corbett (1987). These findings have particular significance in light of other data indicating that since 1973 the proportion of women who are robbed has substantially increased (Smith, 1987).

In addition to gender effects there is also evidence that age influences the severity of robbery victim psychological reactions. Bourque et al. (1978), for example, found that elderly robbery victims showed crisis reactions more frequently than young or middle-aged victims. Robbery victims over sixty were reported by Maquire and Corbett (1987) to be

almost three times more likely to indicate that they were "very much affected" by what happened. Gabor et al. (1987), on the other hand, found no gender or age differences among the armed robbery victims they studied. Occupational status was also not related to subsequent psychological problems.

Resick (1987a) found that female victims who reported a history of mental health problems tended to experience greater symptomatology in the first half year following the robbery. Men who had histories of prior treatment of depression and suicide attempts suffered more general distress and lower self-esteem. Gabor et al.'s (1987) research corroborates these findings. They found that the armed robbery victims most seriously affected were those already experiencing familial, financial and health problems.

Female victims of robbery having an existing network of people with whom they can talk have been shown to have less distress six months after the offense (Resick, 1987a). The value of an established support system has also demonstrated by Maquire and Corbett (1987) who reported that divorced, separated and/or widowed victims were more than twice as likely to indicate they were severely affected after being robbed.

Crime characteristics. U.S. statistics indicate that physical force is used by offenders in approximately 50% of all robberies, roughly one-third of victims are injured and approximately 10% receive medical attention (Block, 1989; Conklin, 1972; Cook, 1986; Harris, Louis & Associates, Inc., 1984; Waller, 1989). Canadian data show that physical force is used in 74% of robberies or attempts, 35% of victims stay in bed all or part of the day because of the incident, and 24% later receive medical attention (Sacco & Johnson, 1990). The difference between U.S. and Canadian robbery victims' use of hospital care is most likely a reflection of the fact that 1 in 3 Americans are not covered by health insurance or by public medical services.

Block (1989) found that robbery victims who put up resistance are less likely to have something taken. Non-forcible resistance had little effect on the likelihood of the victim being injured. However, if he or she forcibly resisted the chances increased that they would be attacked (69%) and physically hurt (44%). Gabor et al. (1987) also found that robbery victims who resisted were more likely to suffer from physical disorders (82%) than those who did not offer resistance (54%). Cook (1986) warns that the available data are not sufficient to support definitive conclusions about whether resisting a robber's demands is advisable. If successful, one might hypothesize that resisting a robber may instill a greater sense of control which, in turn, may reduce post-crime negative feelings of helplessness. However, if unsuccessful, not only are the subsequent feelings of helplessness likely to be exacerbated, but the physical costs may also be high. Independent of whether the resistance was successful, Gabor et al. (1987) found that there was no appreciable difference in the psychological well-being of armed robbery victims who offered resistance compared to those who did not.

Resick (1987a) studied the association between seven assault variables (relationship with offender, number of perpetrators, weapon use, physical force, duration, injury incurred and threat of violence) and the psychological reactions of robbery victims. Female victims who were acquainted with the offender reported having self-esteem problems and the extent of threats was found to be associated with fear and elevated PTSD symptoms. Surprisingly, the assault variables did not play a role in the reactions and recovery of male robbery victims.

Normandeau (1981) reported slightly different results. He found that "duration" and "frequency" influenced the reactions of people robbed at gun-point. Specifically, victims who had gone through a prolonged robbery and/or had been the victims of repeated robberies suffered the most severe reactions. Other crime characteristics found to negatively influence psychological outcomes were (1) the perpetrator wearing of a mask, (2) the proximity of the weapon to the victim, and (3) yelling or other noise making designed to intimidate victims.

Post-victimization factors. The only study to examine robbery victim post-crime cognitions was conducted by Lejeune and Alex (1973). They found that "the one effect, observed uniformly and without exception" in their study of 24 mugging incidents in New York, was a heightening of the victims' sense of vulnerability and mistrust. Being robbed of one's possessions left victims questioning their previously held assumptions about themselves, others, and their environment. These feelings subsided with time but all of the victims studied by Lejeune and Alex emerged from the mugging with a new sense of vulnerability to the attacks and demands of strangers. The mugging victims also reported an extreme awareness of themselves as potential targets of another mugging.

Conklin (1972) reported that approximately three in four robbery victims changed their behaviour patterns as result of being robbed. Most commonly victims said they took more precautions handling money or indicated they were more suspicious of strangers. Shapland et al. (1985) reported that robbery victims suffered many social effects, particularly a curtailment of social life because of fear of future attack. Cohn (1974) found that robbery victims commonly made "rational responses" designed to prevent future robbery such as installing new locks and putting bars on windows. In order to reduce their anxiety some robbery victims refrained from going out at night, changed their place of employment, moved to a new house or acquired weapons for self-defense. None of these researchers reported data on whether these strategies were associated with fewer subsequent psychological problems.

Wirtz and Harrell (1987b) studied the association between behavioral strategies and post-crime coping with 236 crime victims, including 34 victims of robbery. The most frequent actions taken by robbery victims were to stay home more (32.4%), be more cautious (29.4%), and change jobs (20.6%). Unfortunately the data were not analyzed by type of crime. As a group, however, victims who stayed home more had higher levels of psychological distress one month after the crime as well as six months later.

Curiously, Resick (1987a) found that female robbery victims who avoided being alone, changed their physical exercise routine, and took a self-defense course reported greater, rather than lesser, sypmtomatology. These behavioural strategies would appear to be adaptive yet did not positively affect female victims' abilities to cope. On the other hand, as might be hypothesized, male robbery victims who moved away (a maladaptive, avoidance strategy), were found to experience higher levels of distress on three of the four outcome measures. Resick concluded that robbery victims may have intended the changes in their life style to be coping mechanisms but their behaviour usually increased the emotional problems they experienced rather than decreasing them.

Social support was found to be related to post-robbery psychological reactions by Resick (1987a). She reported that perceived social support is important for the short-term prevention of symptoms and maintenance of self-esteem and for the long-term recovery of PTSD symptoms in females. Social support was also found to be important for males, but it was only related to the development of longer-term adjustment problems. Interestingly, the total number of people talked to was related with greater, not lesser, subsequent distress for both males and females. Interpreting this result, Resick reasoned that this finding could be a reflection of the fact that people who are distressed are more likely to seek out others. Overall, she concluded that "better reactions from loved ones and others were associated with less symptomatology and better self-esteem" (p. 65).

Research has shown that robbery victims generally rate law enforcement officers as being sensitive to their needs (Bourque et al., 1978; Normandeau, 1981; Woytowich, 1986). It has been suggested that the more sensitive response of police officers to robbery victims compared to other crime victims (i.e., burglary) is in part attributable to the fact that the police find it relatively easy to empathize with the emotional response of someone who has had their life threatened and perhaps been roughed up.

Resick (1987a) found that robbery victims who received postcrime treatment also reported greater levels of distress. This finding is difficult to interpret however as the length of treatment, type of service received nor the quality of the service were assessed. Participation in the criminal justice system was found to have little, if any, effect on the participants' psychological functioning following the crime. They received no less or more support than those victims who did not enter into the system and were no more likely to have received any kind of treatment.

Bourque et al. (1978) reported that 50% of the robbery victims they studied had been either robbed or burglarized at some earlier data. However, they found no significant relationship between the incidence of prior victimization and level of crisis. Resick (1987a), on the other hand, reported that there was a clear connection between female robbery victims' history of prior victimization and their reactions to and recovery from the incident. Childhood emotional abuse, sexual abuse, and criminal victimization were particularly significant predictors of psychological sequelae. For males, Resick found a prior history of victimization was strongly predictive of long-term reactions but played only a small role

within the first month after the offense. Leymann (1985) and Normandeau (1981) also found that prior victimization was associated with increased psychological problems for victims of bank and/or armed robbery.

Summary

A significant number of Canadians are victimized every year by robbery. The crime is usually marked by violence and loss of property. The psychological sequelae range from mild upset and anger to post-traumatic stress disorder. Virtually every victim experiences some emotional and/or behavioural reaction and approximately 10-30% of robbery victims suffer "severe" short-term trauma. After six months the effects appear to diminish. However, between 5-10% of victims continue to suffer significant psychopathology.

After being robbed, women suffer more than men, and the elderly experience more distress than the young. Prior health problems put robbery victims at greater risk whereas an established social support network can buffer negative psychological consequences. It appears that the use of threats of violence and a weapon may also exacerbate the trauma of robbery. The data is equivocal with regard to the effectiveness of behavioural coping such as staying at home more often or moving. Robbery victims who receive supportive help tend to get over the negative effects more readily. Finally, repeated victimization compounds the psychological distress experienced by victims of this criminal offense.

Kidnapping, Torture & Terrorism

The reader should not assume that because kidnapping, torture and terrorism are included under the same heading they cause identical psychological problems for victims. It became apparent when reviewing this literature that these crimes do, however, share many common features. A victim of kidnapping, for example, may be subjected to torture so as to obtain his or her cooperation or receive information. In addition, because relatively few people are subjected to these crimes researchers studying the consequences of one of these offenses often group subjects together to increase their sample size. Therefore, for convenience and simplicity kidnapping, torture and terrorism will be discussed together.

The data sources for this section are subject to the many of the same validity concerns discussed earlier. All of the studies lack rigorous research design elements, especially random selection procedures and control groups. A particular problem seems to be the complete reliance on the memories of victims who in some cases were victimized many years earlier. Nonetheless there is a great deal of consensus in the literature about the psychological sequelae of terrorist experiences (Corrado & Tompkins, 1989).

Statistics

Since World War II Canada has provided refuge for well over 400,000 people from all parts of the world (Allodi, 1989). Many of these refugees left their homelands to escape violent persecution, including torture. Between 1975 and 1985, hundreds of thousands of people have been tortured or killed around the world as a result of government sanctioned terrorism. United States statistics indicate that during this period anti-state terrorist events and threats, excluding kidnapping, numbered around 5,000 (in Corrado & Tompkins, 1989). Estimates are that between 25,000 and 75,000 child abductions occur in the United States each year (Agopian, 1984).

Short and long-term psychological effects

In discussing the psychological effects of terrorism, Corrado and Tompkins (1989) make a distinction between terrorism that is condoned and/or conducted by the state (e.g., political torture) and terrorist activities that are directed against the state (e.g., kidnapping). Recognizing the substantial limitations in the amount and quality of research available, they nevertheless developed a model for comparing the impact of these offenses and concluded that although the victimization processes involved in state and anti-state terrorism are essentially the same, and post-traumatic stress disorders are common, severe disorders are more commonly associated with state terrorism.

Fields (1980), on the other hand, concluded that the empirical data suggest the similarities in the psychological consequences of terrorism that are independent of whether the terror is state or anti-state. She described the process of terrorism as "the exertion of an unpredictable irresistible strength that threatens annihilation" (p. 46). In its victims it creates a sense of powerlessness and the psychological shock of any severe trauma. She postulated that stress responses to acts of terrorism are generated as a result of threat to life, threat to bodily integrity, threat to security, and threat to self-image.

Thus, regardless of the objectives of the terrorist activity, its basis process involves an unpredictable, powerful force threatening the victim with death. The extreme stress the situation creates can leave victims feeling completely helpless and powerless. The result is severe psychological trauma often lasting years after the terrorist incident is over (Flynn, 1989; Symonds, 1980; 1982).

The bulk of the literature on the psychological effects of prolonged detention, torture and terrorism comes from studies of Holocaust survivors of Nazi concentration camps, American prisoners of war in Southeast Asia, and political prisoners from Latin America and the Soviet Union. In state terrorism, torture is usually initiated soon after arrest. The victim is frequently beaten and/or threatened before the first interrogation session. Distinctions are often made between mental and physical torture but because they commonly take place simultaneously, this differentiation is made difficult. Some of the more frequently used methods of physical torture include beating and kicking, burning, prolonged positioning

Table 3.
The most frequent psychological consequences of torture †

neurological or mental sequelae	
reduced memory	sleep disturbances
inability to concentrate	nightmares
anxiety	visual disturbances
depression	vertigo
fear	paresthesias
lability, introversion	changed identity
lethargy, fatigue	

† adapted from Rasmussen & Lunde (1989)

(e.g., standing), rape, exposure to extreme cold and dental surgery. Mental torture may include threats, solitary confinement, sleep deprivation, sham executions and continuous exposure to white light or noise (Rasmussen & Lunde, 1989). The effects of torture are both physical and mental but the victim's psychological problems are usually more severe and debilitating (see Table 3). Torture can also affect the victim's family in so far as they will have to cope with the resulting personality changes which often occur.

The severe and debilitating psychological effects of extreme state terrorism like that experienced by Nazi concentration camp survivors have been described by Corrado (1989). The arrest and detention initially produces an overwhelming sense of disorientation, disbelief and debilitating fear. Once the gravity of the situation is grasped profound despair commonly sets in. A functional apathy eventually develops. The victim's interests revolve solely around self-preservation. Non-adaptive emotions are never displayed and after a one or two-week period severe withdrawal and depression marked by the complete inability to respond, to think, or to feel is experienced.

Three profiles among survivors have been identified. After release victims suffer serious mental disorders that prevent them from ever having a "normal" life, simply deny having suffered any lasting impact, or become engaged in a life long struggle to overcome their problems and reintegrate back into society. Long-term psychological reactions include sleep disturbances, anxiety, cognition and memory disturbances, paranoia, delusional thinking, obsessive-compulsive thinking, psychosomatic disease, personality change, denial, and severe depression. Based on the limited available data, it has been estimated that the chances of suffering from one of more of these symptoms after a concentration camp experience approaches 100%.

Gonslaves (1990) conducted interviews with 32 Chileans who were detained, tortured and subsequently exiled to the United States. Out of the total sample, 20 individuals reported direct experience with torture and detention in concentration camps. Seventeen of these torture victims reported psychological reactions linked to the experience. Most of the victims complained of involuntary flashbacks/recall of the torture, denial and memory disturbances. In addition, many of the symptoms they experienced while being tortured returned if they found themselves in a situation resembling the torture setting.

Sack, Angell, Kinzie and Rath (1986) conducted a study of 40 Cambodian students and their families who had survived between two and four years of concentration camp living and/or forced labour under the Pol Pot regime. The victims complained of sleeplessness, difficulty concentrating, nightmares, guilt, emotional numbness, recurrent recollections, denial and nervousness. It was determined that they all had sufficient psychopathology to warrant a diagnosis of post traumatic stress disorder.

Allodi and Rojas (1985) studied a sample of 29 torture victims, 46 refugees, and 53 other immigrants living in Canada and found that the indices of mental distress and social maladaption were significantly higher for torture victims and refugees than those of other immigrants up to ten years following their traumatic experience. The children of these victims, on the other hand, showed no ill effects (Allodi, 1989). In contrast, Dreman and Cohen (1990) examined children whose parents were killed by terrorists in Israel and found that the experience had a profound lasting impact on their lives. Three of the four children they interviewed expressed fears of loss of control, pessimism, reenactment behaviour, anxiety, shame, guilt, denial, impulsive control problems, antisocial behaviour and social problems. An earlier study by Allodi in 1980 (cited in Allodi, 1989) also found that the children of political persecution and torture have lingering psychological problems. The children showed reactions of social withdrawal, chronic fear, depressive moods, clinging and overdependent behaviour, sleep disorders, somatic complaints and arrest or regression in social habits and school performance. The difference between these findings and those in the 1989 study by Allodi can be attributed to the use of standardized measures and control groups in the later study or to the fact that the 1980 study involved children who were permanently separated from their parents and had inadequate parental substitutes or social bonds (Protacio-Marcelino, 1989).

Anti-state terrorism includes hostage taking, kidnapping and skyjacking. In these situations, victims are commonly subjected to conditions of isolation, visual deprivation, physical restraint, abuse, and threat of death. Consequently, many experience feelings of isolation, disorientation, uncertainty, helplessness, vulnerability, fear and anxiety. Hallucinations are also common (Siegel, 1984). A variety of psychological reactions have been reported by ex-hostages including: inability to concentrate; dramatic mood swings; startle reactions; intrusive images; and burn-out associated with the inability to deal with the event (Hatcher, 1987).

Weisaeth (1989) reported on the psychological reactions of 14 Norwegian sailors who were kept under arrest for 67 days in Libya and subjected to a variety of physical and psychological tortures. Interviews conducted soon after their release and six months later indicated that the most immediate reactions to the extreme stress were fear, depression and rage (see Table 4). Six of the victims had developed post-traumatic stress disorder by the first interview, one developed it two months later and, in spite of treatment, the same seven sailors still suffered from PTSD six months later.

Table 4.
Symptoms reported by Weisaeth (1989) to have occurred among 13 torture victims †

	n
sleep disturbance	11
fear of dying	11
anxiety	9
depersonalization	6
repetitive nightmares	5
severe hopelessness	5
severe anger	5
tremor	4
fear of madness	4
amnesia	4
numbing	4
reduced self-esteem	3

† n = number of victims reporting the symptom

Fields (1980) conducted a study of 12 of the 100 persons held hostage in 1977 by Hanafi Muslims at the B'nai B'rith headquarters in Washington, D.C.. One year after captivity the hostages were described as "suffering from anxiety syndromes, and psychoneurotic tendencies related to the anxiety. They exhibited problems in sexuality, sleep and dreams, and memory and working functions" (p. 82).

An effect unique to anti-state terrorism that commonly arises out of a hostage-taking situation is the Stockholm syndrome (Ochberg, 1978). Named after a bank robbery incident

in Stockholm, Sweden, in 1973 where 4 bank employees were held captive in a vault for 131 hours by an escaped prisoner, the syndrome has been described as an intense form of psychological transference and infantilism resulting from shared conditions of stress and survival (Symonds, 1980b; 1982). After the initial shock has passed and victims come to the realization that their life is not in immediate danger, both the captors and the hostages often come to the realization that their mutual survival depends on how the authorities decide to resolve the standoff. A paradoxical situation is created in which the hostage taker is perceived by the victim as his or her protector, whereas the police, by their refusal to agree to the captor's demands, are seen as the source of danger. The combined effects of terror, shock, and anxiety followed by exhaustion, hunger, boredom and perhaps most importantly, discussion of personal information can create a situation conducive to transference. As reality becomes distorted victims come to identify with their captors and share many of their concerns and opinions. The syndrome can persist beyond the immediate crisis as victims have been known to continue to express extreme fear and distrust of authorities. Factors which seem to promote the syndrome are (a) the passage of time, (b) the quality and intensity of the incident, (c) the amount of dependence placed on the captor by the captive for survival, and (d) the "psychological distance" of the victim from his or her government (in Flynn, 1989). It has been suggested that this phenomenon may have occurred in the kidnapping of Patricia Hearst (Symonds, 1975).

Much of the current information of the psychological effects of child abduction comes from the popular media, including newspaper and magazine articles. Agopian (1984) reviewed this literature and reported that an array of disorders including assaultive behaviour, insomnia, poor peer relations, physical and sexual abuse, distrustfulness of authority figures and relatives, and fear of personal attachments were common. He concluded that this type of crime may be more traumatic than other kinds of kidnapping because the offender is a trusted and loving parental figure. In an effort to empirically verify previous anecdotal findings, he conducted a study of five abducted children from ages 6 to 11 who were reunited with their legal custodian and identified two distinct response patterns depending primarily on the length of time the children were sequestered. The children who were detained for a short period of time and treated well by their captors developed only mild short-term trauma characterized primarily by worry, fear or crying. However, young children who were detained for periods over six months displayed severe psychological trauma and profound social disorders. These victims had developed an affection for their captors and did not remember their previous lives.

The emotional impact of child abduction has also discussed by Gill (1981). Using clinical case studies he concluded that the effects of being abducted can be devastating on children. The combination of fear, restricted movement, and the gradual influence of the abductor combine to make the child lose self-confidence and mistrust people around them. Often they feel insecure, unloved and angry at both their captor and the parent left behind for not coming to see them. Most children return home unstable, afraid, and completely dependent on loved ones. The psychological impact may be compounded by the fact that they often need medical attention and have missed school. Children who have been abducted

for extended periods of time might have to repeat a grade which can cause more problems. Quoting the work of a psychiatrist who has worked with stolen children in Florida, Gill reported that the long-term effects can also be profound and last years. As they grow, the children's fears grow rather than diminish. They often become antisocial and angry at society for abandoning them (i.e., there are few therapy centres for abducted children).

One of the most frequently cited studies of the effects of kidnapping on children was conducted by Terr (1982; 1983). In 1976 in Chowchilla, California a school bus carrying 26 children was commandeered at gunpoint by three kidnappers. The victims were driven for 11 hours in two boarded-over vans and buried alive for 16 more hours until two of the oldest boys dug the group out. Terr interviewed most of the victims five to 13 months after the kidnapping and again four years later. The short-term effects were that every child suffered from post-traumatic emotional problems including misperceptions, fears of further victimization, hallucinations, personality change and repeated nightmares. Certain symptoms became more evident as time passed. They included intense shame, thought suppression, denial, pessimism, death dreams, and the continuous dangerous reenactment of the event in play. In sum, every child was observed to be suffering from what appeared to resemble PTSD as many as four to five years after the incident. Furthermore, brief treatment provided sometime earlier did not prevent these symptoms from developing.

Flynn (1989) has reviewed much of the case studies and laboratory research of the effects of terrorism and hostage taking on both adults and children and concluded that victims suffer serious and long-lasting damage to their physical, mental, and emotional health. The experience is so damaging to the mind and body that victims never return to the way they were before. She summarizes the literature by stating that "the trauma sustained by victims of terrorism appears to be of the magnitude that is not an exaggeration to analogize the experience to an interstellar catastrophe during which planets are forever forced off their trajectory" (p. 72).

Moderator variables

Pre-victimization factors. Agopian (1984) found that young children who were abducted suffer more extreme and long-lasting reactions than older children. Similar age related findings were reported by Eitinger (1982) Fields (1980). Terr (1982; 1983) reported a relationship between the clinical severity of symptoms among young kidnapping victims and preexisting family pathology, family problems, prior individual "vulnerabilities", and lack of community bonding.

Prior experiences with traumatic stress have been shown to be inversely related to psychological reactions in two groups of terrorism victims (Fields, 1980). The more stress the victims' were under before the incident, the greater were the emotional reactions to their victimization. On the other hand, victims of terrorism who have had prior training in adaptive strategies such as military or some diplomatic personnel may be able to mobilize a

variety of behaviours and cognitive mechanisms that would stave off some of the adverse effects of terrorist crime (Tinklenberg, 1982).

Personality factors may also influence coping ability. Ford and Spaulding (1973) found that U.S. navy personnel imprisoned in North Korea for 11 months in 1968 who had passive-dependent personalities adapted less well to the experience than crew with healthy or schizoid personality types.

Crime Characteristics. The effects of terrorist activity on the psychological outcomes of victims appear to some extent to depend on the duration and intensity of the incident (Corrado & Tompkins, 1990; Tinklenberg, 1982). The type of treatment accorded by the abductor and the length of time in illegal custody influenced the psychological reactions of the child victims studied by Agopian (1984). Children held for short time spans never developed a loyalty or identification with their captors and thus did not suffer severe psychological problems when they were returned to their legal guardian. Gonslaves (1990) found that as the length of detention increased political torture victims tended to emphasize the psychological effects rather than the physical aspects of their ordeal.

The mental health scores of people who are tortured also appears to be related to the intensity of the violence to which they were subjected (Allodi and Rojas, 1985; Eitinger, 1982). The degree of humiliation, ego threat, psychological and social isolation experienced by the victim are all significant factors (Flynn, 1989).

Post-victimization factors. Allodi and Rojas (1985) reported that torture and refugee victims with low scores on a scale measuring dogmatism and authoritarianism had higher mental health scores than victims who scored high on the scale. Allodi (1989) later suggested that this result was a reflection of coping style. The victims who showed few ill effects had an internal locus of control that shielded them as well as their children against the trauma experienced by others. He also postulated that the safety of Canadian society and large refugee community in Toronto where the sample was selected contributed to the generally satisfactory health of the victims' children.

Protacio-Marcelino (1989) reported that the children of political detainees in the Philippines during the early 1980's were buffered against many negative effects if they had a good emotional support network and strong bonds with families of other political detainees. Terrorism victims with good social support were also shown to experience less psychological distress after they were released (Fields, 1980).

Agopian (1984) found that support and therapy were important for children who were abducted and later returned to their legal guardian. Rasmussen and Lunde (1989) reported that 90% of torture victims treated at the Centre for Torture Victims in Denmark improved significantly after a year of therapy. Summarizing the literature, Flynn (1989) noted that the availability of treatment and system response to terrorism victims and their families is a major factor mediating the extent of trauma felt by those affected.

Summary

While the data base is small, the available evidence indicates that the psychological impact of state conducted terrorism can be severe. The apocalyptic sense of despair it creates among its victims and the rest of society has led some to describe it as one of the most dreaded victimization experiences. The probability of being seriously affected approaches 100%.

The psychological sequelae of anti-state terrorism, on the other hand, are not as severe but nonetheless significant. Short-term psychological effects reported by hostage victims include poor concentration, intrusive thoughts and nervousness, fear, depression and rage. A minority of these victims continue to suffer from long-term distress ranging from sleep disturbance and memory problems to post traumatic stress disorder. The impact of child abduction may be more serious and long-lasting because of the violation of trust that is involved. Some studies have shown that abducted children develop psychological problems, including symptoms of PTSD, that increase rather than decrease in severity as time passes.

The research on moderator variables is also limited. With regard to both state and anti-state terrorism, it appears that the longer and more violent the victimization experience, the worse the psychological reactions become. Young children who are kidnapped are particularly susceptible. Social support and treatment intervention may also be important moderators to the longer-term consequences of these offenses. It is unclear what effect, if any, the development of the Stockholm Syndrome during hostage-taking situations has on subsequent outcomes.

Assault

For the purposes of this discussion the criminal offense of assault will be divided into three headings: (1) non-domestic assault, (2) domestic violence, and (3) child physical abuse. The first section entitled non-domestic assault will, by definition, cover the psychological reactions of victims to all types of assault (i.e., assault causing bodily harm, common assault, assaulting a police officer) excluding the effects of violence occurring between men and women in the home and the psychological sequelae of children who are physically (not sexually) abused by their caregivers. The latter two subcategories of assault will be discussed in the sections that follow.

Non-Domestic Assault

Statistics

Victimization surveys conducted in the early eighties by the United States Department of Justice and the Census Bureau reveal that assaults account for 13% of crime committed in that country (Frieze et al., 1987). Findings of the second British Crime Survey indicate that common assaults account for 12% of crime. Almost 1.5 million assaults were committed in England and Wales during 1983. The incident rate was estimated to be 47 per 1000 (Hough & Mayhew, 1985).

Canadian Urban Victimization Survey statistics put the incident rate of assaults at 57 per 1000. It was estimated that 285,700 incidents occurred in 1982 (Himelfarb, 1984). Results of the first national (both urban and rural) criminal victimization survey conducted in Canada conducted in 1987 indicated that the rate of assault was 68 per 1,000. A total of 1,381 assaults were recorded during the survey (Sacco & Johnson, 1990). Eighty seven of every 100 violent crime offenses reported to the police are assaults (Statistics Canada, 1991). Data from both Canada and England indicate that almost two-thirds of all assaults are not reported to the authorities (Hough & Mayhew, 1985). Included in these figures are incidents of child sexual abuse and domestic violence. The rate of assault subtracting out these special subcategories has not been tabulated by government agencies.

Short and long-term psychological effects

Although the findings are not always consistent and data specifically on non-domestic assault victims scarce, research has shown that the psychological effects of this offense can be traumatic. One of the few studies to separate victims of non-domestic assault from victims of sexual assault and domestic violence was conducted by Wirtz and Harrell (1987b). As part of a larger study of the Pima County, Arizona, Victim/Witness Assistance Program they interviewed a variety of crime victims twice: once, in person, within roughly four weeks after the crime and again, by telephone, approximately six months later. Results showed that similar patterns of trauma were experienced by the three groups of victims (see Table 5). Victims of sexual assault exhibited the greatest levels of distress but domestic assault and non-domestic assault victims appeared to experience almost equal degrees of trauma. These findings held for both the initial assessment and the follow-up.

Kilpatrick et al. (1985) conducted interviews with a representative sample of 2,004 adult women in South Carolina. Of the 547 women who reported being previously victimized, 48 respondents were identified as having been victims of aggravated assault. Incidents were defined as aggravated assault if the victim was attacked by an assailant with a gun, knife or other weapon, or the victim was attacked without a weapon but with the intent to kill or inflict serious injury (domestic assaults were not differentiated). The results revealed that victims of aggravated assault did not differ from the control group of

Table 5.
Mean levels of psychological trauma at one and six months, by type of victimization †

measure of distress	non-domestic assault		domestic assault		sexual assault	
	1 month	6 months	1 month	6 months	1 month	6 months
anxiety	2.9	1.9	3.0	2.0	3.2	2.1
stress	2.0	1.3	2.3	1.4	2.3	1.4
dismay	2.3	1.8	2.5	1.8	2.7	1.9
fear	2.3	2.2	2.2	2.2	2.6	2.7

† adapted from Wirtz & Harrell (1987b; 1987c)

nonvictims in history of nervous breakdowns or suicide attempts. However, the victims did show significantly higher rates of suicide ideation (14.9% versus 6.8%).

In order to ascertain whether these suicidal thoughts preceded or followed the victimization, Kilpatrick et al. (1987) conducted follow-up interviews with 42 of the aggravated assault victims. An average of 10.5 years had passed between the offense and the follow-up interview. They were able to determine that 37% of the assault victims subsequently developed post traumatic stress disorder and that 10% were still suffering from PTSD at the time of the interview.

Brown and Yantzi (1980) conducted a survey in the Kitchner-Waterloo area of Ontario and reported that crimes committed against "the person" (including assault) had the greatest impact on victims. Sixty four percent of these victims indicated that the crime had a "fairly" or "strong" impact on their lives and 46% experienced more than two severe reactions including generalized fear, sleeplessness, headaches, and distrust. Included in their sample of 23 assault victims were 7 victims of sexual assault. It is not known to what extent the rape victims' responses accounted for Brown and Yantzi's results.

Harris and his associates (1984) conducted a New York based study of the consequences of crime for the state's crime victims compensation board. Of the 61 assault victims they interviewed 56% indicated that the mental or emotional suffering was very or somewhat serious. In addition, Krupnick and Horowitz (1981) noted that victims of beating and stabbing often suffer from anxiety attacks, insomnia and fear of revictimization. Some also feel partially responsible, but one of the most frequent responses is intense anger at the source of the injury.

Results of the 1984 British Crime Survey revealed that 24% of crime victims who were wounded felt that fear, worry, nervousness, health problems, stress and/or upset were

the worst problems faced as a result of the incident (Hough & Mayhew, 1985). Forty percent of respondents indicated that they experienced emotional problems after being wounded. Twenty six percent mentioned fear, worry and/or loss of confidence, 11% indicated they experienced depression, stress, sleeping, and/or health problems, 5% said they felt upset, and 1% reported feeling angry, frustrated and/or annoyed.

Maguire and Corbett (1987) corroborated many of these findings. They reported that 36% percent of British wounding victims who reported the offense to the police said they were "very badly affected". In the first few days after the event they experienced a wide variety of emotions. Many said they felt intensely angry and/or frightened or mentioned intense feelings of uneasiness, confusion, weakness and/or shakiness. Other respondents indicated they had difficulties sleeping and/or they were unable to do ordinary tasks. Depression, headaches, loss of appetite, crying, and feelings of vulnerability were also noted.[3]

Shepherd et al. (1990) assessed the reactions of 70 victims of assault who went for treatment at the British Royal Infirmary and Dental Hospital in England and compared them to a sample of 52 accident victims also seeking health care. They found that the short-term levels of anxiety and depression were similar for both groups, though the assault victims were more preoccupied with physical symptoms and had more social maladjustment. After three months, levels of anxiety, depression and psychiatric symptoms were all significantly lower for the accident victims. In comparison, the levels of anxiety and depression in assaults victims had remained unchanged. Sixty percent of the assault victims' were determined to be experiencing psychopathology on the General Health Questionnaire after one week. The long-term prevalence of psychiatric disorder was 40%.

Another study was conducted by Shepherd (1990) of 55 assault victims randomly selected from a population of 539 people who attended the British Royal Infirmary during 1986. Information was gathered on the victims after they were examined and again six month later in their homes. Approximately 50% of the victims reported they initially experienced bewilderment and helplessness. The majority said they felt stunned or dazed and then frightened and angry. After a few days roughly 50% indicated they were suffering from depression and accompanying feelings of not being able to make sense of things, nervousness, and shakiness. Overall, 24% of the victims reported they were upset only during the first week and 13% indicated no emotional upset at any time. Slightly less than half, though, had not recovered by six months. Some victims experiencing long-term reactions described repeated vivid flashbacks of the event characteristic of post traumatic stress disorder.

Sometimes people are assaulted, or put themselves at risk for assault, because of the nature of their work. Police officers, for example, are regularly exposed to violent situations and occasionally become the victims of physical aggression. For example, it has been estimated that 22% of police deaths and 40% of police injuries are incurred as a result of intervening in situations involving domestic violence (Kroes, 1985). Although police officers

are assaulted relatively infrequently, many, especially those patrolling high crime rate areas, for their own safety must perform in a constant state of heightened alertness. This continual state of peak preparedness tends to wear them down much as if they were in actual danger. Fear, uncertainty, anger, nausea, and trembling are common psychological reactions reported by police officers in reaction to crisis situations (Kroes, 1985). Research of the specific reactions of the police to physical assault has not been conducted.

Another population of professionals commonly at risk for assault are nursing staff in psychiatric settings (Dawson, Johnston, Kehiayan, Kyanko & Martinez, 1988; Morrison, 1977-78). Lanza (1983) studied the reactions of 40 nurses (both male and female) working at a Veterans hospital who were assaulted by patients. Information was gathered on the staff's short and long-term emotional, cognitive, social, and biophysiological reactions to being grabbed, hit, choked, knocked out and thrown to the floor. About half the nurses indicated no response to many of the questions about their emotional, social and biophysiological reactions. However, Lanza (1984) later reported evidence that nurses may experience intense reactions to being assaulted but are reluctant to acknowledge them because of a perceived role conflict between their experiences as victims and nursing's professional goals. Some staff felt they would be overwhelmed and not able to function if they allowed themselves to admit their feelings (Lanza, 1983). Short-term psychological reactions experienced by at least 30% of the study sample included anger, anxiety, helplessness, irritability, sadness, feelings of resignation, depression, shock, apathy, disbelief, self-blame and dependency. Fear of the patient who committed the assault, anger, anxiety, feeling sorry for the patient, body tension and soreness continued beyond one week.

Additional evidence that the effects of assault can be severe, especially on women, is provided by Koss et al. (1991). They studied the effects of criminal victimization on health and the utilization of health care services with a sample of 26 female physical assault victims. Compared with the average number of physician visits made during a two year period prior to the crime, assaulted women increased their post-crime visits by 15% during the year of the offense. The year following the assault physician visits increased 31%. Two years after the offense they were still up by 15%. Many of these visits were undoubtedly made to receive care for the physical injuries received during the offense. However, it is well known that many people go to their family physician to obtain non-physical treatment. Biles et al. (1979) reported that assault victims made almost three times as many contacts with a professional or other health expert for a nervous condition or mental problems in the year prior to being interviewed.

Moderator Variables

Pre-victimization factors. Gender, low socioeconomic status, and youthfulness have all been shown to correlate with the severity of assault victim outcomes. For example, Maguire and Corbett (1987) found that more than twice as many female than male victims of assault and/or wounding reported that they or their households were "very much" affected by what happened.

Assaulted police officers who have had negative life experiences such as death in the family and financial problems have been found to experience much greater distress compared to those without these prior life events (McMurray, 1989).

Pre-established social support has also been shown to be associated with outcomes. Divorced, separated and/or widowed assault victims or those living alone are three times more likely to report they are "very much" affected compared to married and/or single victims or victims living with others (Maguire & Corbett, 1987).

Crime characteristics. Harris et al. (1984) reported that 74% of the 61 assault victims they interviewed in New York received a physical injury as a result of the crime and 60% received medical treatment or spent time in the hospital because of those injuries. Each year two million Americans suffer injury as a result of assault (Waller, 1989). In Canada, 19% of all assaults involve the use of a weapon. The victim is hit, kicked, slapped, and/or knocked down 62% of the time and 40% of assaults involve the victim being grabbed, held, tripped, jumped or pushed (Sacco & Johnson, 1990). Victims who use non-forceful resistance to assaultive violence are less likely to receive injuries than those who violently resist (Skogan & Block, 1983).

The relationship between the degree of violence in assault and later distress has not been well investigated. Smale and Spickenheuer (1979) found that the seriousness of the injury received by victims of violence (type of crime was not differentiated) was strongly related to the need for retaliation but not feelings of guilt. Victims of violence with lasting physical effects such as scars or partial disability also felt a greater need for retaliation than those not suffering such effects. Shepherd (1990) reported the psychological reactions of the assault victims he studied in England seemed to be closely related to the persistence of the physical injuries they sustained. He suggested that the continued pain and disformity were, in themselves, important causes of emotional distress. Research with police officers, however, has revealed no association between perceived seriousness of assault and post-crime distress (McMurray, 1989).

In cases of assault where the offender is known to the victim prior to the offense the victim tends to suffer more from the incident. Maguire and Corbett (1987) reported that well over half the victims of wounding and threats who had previously known the offender reported themselves "very much" affected compared to under a quarter of those victims who were sure they did not. In general, approximately 43% of assault victims are acquainted with the aggressor (Sacco & Johnson, 1990). However, it is not known what proportion of Maguire and Corbett's sample was made up of victims of domestic violence. This effect may be a reflection of the possibility that victims of domestic violence suffer more psychological sequelae than other assault victims.

Post-victimization factors. As with other crime victims, people who have been assaulted engage in a variety of behavioural coping strategies following their misfortune. Wirtz and Harrell (1987b) reported that 57% of the 58 non-domestic assault victims they interviewed

stayed at home more often after the attack and 26% said they were more cautious. Other notable responses were changing residence (17%), phone (16%) and/or job (16%). Sixteen percent went so far as to purchase and/or carry a weapon in order to protect themselves. Two of these coping responses (changing telephone numbers and staying home more) were found to be associated with higher levels of psychological distress one month after the crime. These responses were also related to long-term psychopathology six month later. From a treatment standpoint, these results suggest that victims who withdraw from their friends and former social activities are particularly a risk to high levels of long-term distress (Wirtz & Harrell, 1987d).

Social support received from others can be valuable to assault victims. Shepherd (1990) reported evidence that suggested the support of significant others (e.g., spouses) is particularly helpful. Parents also proved to be an important source. In contrast to parents and partners, siblings, friends and workmates provided little support for the assault victims in Shepherd's study.

The response of police officers and hospital medical staff to victims of assault does not appear to be as favourable as their reactions to other crime victims (Shepherd, 1990). Wirtz and Harrell (1987b) reported that fewer than one quarter (22%) of non-domestic assault victims were told by the police of a services contact person or group. They also reported a strong relationship between whether the police mentioned the availability of services and whether services were actually received. Wirtz and Harrell suggest that this places assault victims at higher risk of experiencing post-crime trauma compared to other victims in so far as police actions have been shown to have a positive effect on recovery from victimization.

Interestingly, research has shown that when the police are themselves assaulted they apparently do not depend on social support as much as others. McMurray (1989) reported that neither personal nor work-related social support had a statistically significant relation with distress. Of the two sources, work-related support buffered the assault specific stress more.

With regard to the impact of re-victimization, Lanza (1984) found evidence that nurses who had been previously assaulted were not as likely to deny the emotional and social impact of the event. They were more willing to talk with co-workers about their fears and admit their concerns about the negative effects of being assaulted. Smale and Spickenheuer (1979) reported that previous experiences with crime were associated with less need for retaliation for victims of violence. Contradictory results were reported by Shepherd (1990) who found that symptoms indicating loss of self-esteem were more pronounced in victims who had little or no prior experience with violence.

Summary

A serious limitation of much of this research is that very few empirical studies differentiate physical assault victims from those of domestic violence. It is therefore difficult to know whether by including female domestic violence victims in their samples, the studies reviewed here inflate (or deflate) the negative effects of assault on victims. Thus, the statements made in this summary should be considered tentative.

Short-term psychological reactions to assault experienced by roughly 40% of assault victims include anger, difficulty sleeping, uneasiness, confusion, bewilderment, denial, fear and shivering. More serious reactions including depression, helplessness, loss of appetite, nausea and malaise are reported by 20-40% of victims. Most of these effects persist for up to three weeks. Three to six weeks later approximately 15% of victims feel "very much" affected and about 5% have life-long reactions to this criminal offense (Shepherd, 1990).

Some professionals may be particularly at risk for being attacked. Interviews with nursing staff who have been assaulted in the workplace have revealed that approximately one-third experience short-term psychological distress.

Moderators of the effects of assaults have not been extensively researched. Most of the available evidence suggests that women, severely beaten victims, victims who engage in avoidance related behaviours and victims not receiving support from others may be particularly at risk for developing subsequent psychological problems.

Domestic Violence

Statistics

Statistics indicate that domestic violence, specifically abuse by an intimate partner, is pervasive. Approximately 50% of women are battered at some time in their lives by their partners (Walker, 1985). Surveys conducted in the United States reveal that some form of violence occurs each year in 16% of relationships. Based on a sample of 2,000 couples in the U.S., Straus (1978) estimated that 50-60% of partners had experienced at least one previous violent incident. British figures put the incident rate in the range of 5-20% of marriages (McIlwaine, 1989), while Canadian data indicate that it occurs in up to 10% of families (Marcel, 1982). One in three battered women are assaulted weekly or daily in Canada, while slightly fewer are beaten at least once a month (MacLeod, 1980). In 1978 it was estimated that 15,000 battered women sought shelter in transition houses in this country (MacLeod, 1980).

Disturbing as these numbers are, they may represent only the tip of the iceberg. Although the situation is changing, many law enforcement personnel and physicians continue to view domestic abuse as a *private* matter between a man and his wife (Brown, 1984;

Fattah, 1981; Oppenlander, 1982). To illustrate, Swanson (1984) reported that of the 129 referrals made to a shelter for battered women, only three were made by a physician. However, for a variety of reasons, battered women are reluctant to report the matter to the appropriate authorities (Goodstein & Page, 1981; MacLeod, 1980). For example, only 15% of the women who were staying at a shelter for battered women in Saskatoon during 1981-1982 pressed charges or sought a restraining order against their husbands (in Swanson, 1984). Fear of retaliation and the perceived social stigma of being a victim of domestic violence are two of the more common reasons why female victims do not report the crime to the police (Solicitor General, 1985).

Over 90% of spousal assault victims are women (Dobash & Dobash, 1978; McIlwaine, 1989, Solicitor General, 1985). To the best of my knowledge, the psychological effects of domestic abuse on males have not been empirically researched. Schwartz (1987) has examined gender and injury in spousal assault and concluded that "at any level of injury or threat (whether or not physically attacked), spousal assault is 'primarily a problem of victimized women' because women are virtually all of the victims" (p. 43). Therefore, this discussion will focus of the female victims of this offense.

Short and long-term psychological effects

Throughout this discussion the terms wife abuse, spouse abuse, battered woman and victim will be used interchangeably to denote what the literature has described as "Battered Woman Syndrome" (Walker, 1985). Simply stated, the syndrome refers to the physical (including sexual) and psychological abuse of a woman by her husband or any male with whom the woman has had an intimate relationship (Swanson, 1984). The abuse battered women experience can be a combination of three types: (1) physical assault, (2) psychological abuse in the form of constant derogation, taunts, purposeful inconsistencies or threats, and (3) the psychological abuse many of these women experience when they turn to someone for help and frequently find that it is not there (MacLeod, 1980). The psychological abuse is thought to have a greater negative impact on victims than physical abuse.

The Canadian Advisory Council on the Status of Women (MacLeod, 1980) issued a report on wife battering and provided a good "experiential definition" of the problem based on first hand reports of abused women. They wrote "being battered is feeling confused, feeling dead inside, feeling worthless, having no friends ... It's not knowing when he'll turn on the kids - always feeling jumpy, never knowing when it will start again. It is being afraid all the time ... not really trusting anyone or anything. It's feeling guilty and in some indefinable way responsible, even though you're the one who's being beaten" (p. 7).

Much of the research in this field has been conducted by Walker (1978, 1979, 1984, 1985). She, along with others (e.g., Swanson, 1984) have suggested that battered woman syndrome should be included in the American Psychiatric Association's Diagnostic and Statistical Manual as a subcategory of Post Traumatic Stress Disorder (PTSD). Clinical data

indicate that victims subjected to prolonged domestic violence experience many of the same symptomatology as PTSD patients including anxiety and depression (e.g., Gayford, 1975), increased fears and phobias (e.g., Wirtz & Harrell, 1987b) recurring nightmares, sleep and eating disorders (e.g., Hilberman & Munson, 1978), distorted affect, problems with interpersonal relationships and repeated intrusive recollections of the traumatic event (e.g., Walker, 1985).

Wirtz and Harrell (1987a, 1987b, 1987c) interviewed a sample of 61 domestic assault victims one month after the offense and again six months later. Fear, anxiety and stress levels were assessed at the two time periods and it was found that the same sorts of trauma were experienced by domestic violence victims as a comparison sample of sexual assault victims. Whereas the levels of anxiety and stress diminished over time, fear did not decrease for the battered women in their study.

Over the course of one year Hilberman and Munson (1978) interviewed 60 women suffering from serious and/or repeated physical injury as a result of assaults by their partners. They noted that the women had a uniform psychological response to the violence that resembled Rape Trauma Syndrome (Burgess & Holmstrom, 1974) except that the duration of the crisis was unending and the threat of another outburst of violence everpresent. They were constantly agitated and anxious as well as tense and nervous. Anything even remotely connected with the violence triggered intense fear. The women were so certain that something terrible was always about to happen that any symbolic or actual sign of danger resulted in increased anxiety, agitation, pacing, screaming and crying. Sleep disturbances were universally experienced. Their vigilance made it difficult to relax or fall asleep and when sleep did come, it was accompanied by nightmares with themes of violence and danger. In contrast to their dreams in which they resisted the aggression, their waking lives were marked by passivity and an inability to act. The battered women felt a pervasive sense of hopelessness and despair about themselves and the future. They felt fatigued, incompetent, unworthy and unlovable and were consumed with guilt and shame. All of the women interviewed believed they deserved the abuse.

Many battered women complain of somatoform disorders including somatic complaints, conversion symptoms and somatization (Blair, 1986; Gayford, 1975). The women in Hilberman and Munson's (1978) study made frequent visits to clinics for headaches, choking sensations, hyperventilation, asthma, chest pain, gastrointestinal symptoms, pelvic pain, as well as allergic reactions. These symptoms were often associated with body sites of previous beatings.

The abuse of drugs is also common among victims of domestic violence (Hilberman & Munson, 1978; Swanson, 1984). In a study of 100 battered wives in Great Britain, Gayford (1975) reported that almost three-quarters were taking antidepressants or tranquilizers. Forty-two percent had contemplated suicide. A study of 218 victims of domestic abuse seeking medical treatment in the United States conducted by Berrios and Grady (1991) revealed that many of the women suffered from chronic medical and

psychological disorders including depression and drug abuse. Sixteen percent of the victims had attempted suicide. In a Yale study of 31 battered women seen in an emergency room, the rate of depression was reported in excess of 50%. Twenty-nine percent had attempted suicide at least once (cited in Goodstein & Page, 1981).

Another victim of domestic violence that cannot be overlooked are the children of battered women. Children raised in households with domestic violence have been reported to suffer from psychosomatic disorders such as asthma, sleep disorders and nightmares (see Resick & Reese, 1986). Levine (1975) conducted a study of 117 children, ages 6 months to 14 years, from 50 families in which it was known that intraparental violence took place. The behavioural and psychological problems most frequently observed were truancy from school (36%), anxiety disorders (18.8%), aggressive behaviour and hostility (11.1%), and insomnia (8.5%). Levine noted that in most families the violence was restricted to husband and wife but in others the beatings spread through the household. More will be said about the consequences of child physical abuse in the next section.

Moderator variables

Pre-victimization factors. A search of the literature revealed that there is no empirical evidence linking social class, ethnicity, age and education with subsequent psychological stress. There is, however, some evidence that women who have not completed high school and are unemployed are less likely to leave an abusive relationship (Gelles, 1976).

A pre-victimization variable that has been shown to place women at greater risk for abuse and its psychological sequelae is childhood experiences. Battered women report that they were often victims of incest or some other form of child abuse earlier in their lives (Hilberman & Munson, 1978). In addition, they frequently witnessed the abuse of others and were raised to conform to traditional feminine roles (Goodstein & Page, 1981; Walker, 1985). These early experiences are believed to increase battered women's vulnerability to subsequent depression and helplessness (Walker, 1985). Some support for this theory has been provided by Gelles (1976) who found that battered women who had experiences with and exposure to violence as a child were more likely to remain in their abusive relationships.

Crime characteristics. Statistics indicate that one in three female homicide victims are killed by their husbands or boyfriends (in Blair, 1986). In 6% of all cases the violence involves punching, kicking, biting, beating, and attacks with a gun or knife (Straus & Gelles, 1986). In about one-third of cases, medical treatment is required and received (MacLeod, 1980). Approximately one-quarter of victims are admitted to hospital and 13% require major surgery (Berrios & Grady, 1991). Injuries are most frequently inflicted to the face, rest of the head and to the upper body. Bruises, followed by lacerations, bone fractures and choking are the most common physical injuries inflicted.

Unfortunately, there is little evidence relating the seriousness or duration of abusive relationships with psychological distress. Mullen et al. (1988) reported that women who

were battered on three or more previous occasions, or so severely to require medical attention, had more psychiatric symptomatology. The only other study providing a hint that there may be some connection between these variables was conducted by Gelles (1976) who found that the more severe and frequent the violence, the greater the chances are that abused women will seek outside intervention.

Post-victimization factors. Berrios and Grady (1991) interviewed 218 victims of domestic violence who sought treatment at a hospital in San Francisco and reported that 86% had suffered at least one previous incident of abuse and approximately 40% had previously sought medical care for their injuries. A question commonly asked in light of these statistics is why do women return to their homes after being abused if they know that the chances are high that they will be beaten again. Given the empirical evidence showing that the compound effects of multiple victimization over time can cause serious psychological problems (e.g., Walker, 1978, 1985), some discussion of this topic seems appropriate.

Star (1978) compared the personality profiles of 57 battered and non-battered women and found that contrary to the beliefs of some, women who remain in abusive relationships are not masochistic. The battered women in their study showed no signs of being submissive people but rather were repressing anger, timid, emotionally reserved and had poor coping skills. Their results pointed to passivity, rather than the need for maltreatment, as the more appropriate reason why abused women endure repeated physical beatings.

The process of learned helplessness (Seligman, 1975) has also been posited to explain battered women's reactions to repeated abuse and answer the question why many do not leave their relationship with the offender. Walker (1978) suggests that sex role socialization may be responsible for women staying in abusive relationships. Not only those who have been abused, but many women learn that their voluntary responses are relatively ineffective in determining what happens to them. Repeated derogation by others instills a sense of helplessness and cognitive set in abused women that there is nothing they can do to change the situation. Much like Seligman's dogs which were repeatedly shocked and eventually ceased trying to escape, women who are abused need to be shown the way out repeatedly before change is possible. The battered woman's belief that she is powerless is the most difficult obstacle to overcome when attempting to help these victims (Blair, 1986). In support of Walker's theory are empirical data showing that battered women value men's approval more than other women's, battered women perceived their fathers and husbands as more likely to hold rigid stereotypical gender attitudes, and females are more prone to depression, especially if they are married (Walker, 1985).

Once having fallen into the learned helplessness syndrome the battered woman's energy is drained. The abusive relationship is maintained by almost constant psychological derogation that results in a lowering in self-esteem. Rather than random or constant physical assault, there is a cycle consisting of three relatively distinct phases: (a) tension building; (b) acute battering; and (c) calm, loving respite. These phases vary from couple to couple and within relationships.

In conclusion, it is important to note that while the learned helplessness theory is important in understanding the psychological paralysis of battered women, there are other factors such as patriarchal societal attitudes (Dobash & Dobash, 1978) and economic realities (e.g., some women are completely financially dependent on their spouses) that contribute to the cycle of abuse in many families (Gelles, 1976). Until these factors change it is unlikely that the cycle of abuse will be broken.

In addition to learned helplessness, other attributional processes have been postulated to account for abused women's psychological sequelae. Specifically, battered women have often been cited as blaming themselves for the violence (Frieze, 1979; Hilberman & Munson, 1978; Walker, 1979). Self-blame among battered women increases if they were raised in a violent family, if they already have low self-esteem, if their spouses have successful occupations and if the physical abuse is not severe (see Frieze et al., 1987). Miller and Porter (1983) interviewed 50 battered women who were staying at a shelter in California and collected information on their attributions as well as information on their psychological adjustment. They argued that the degree and meaning of self-blame in domestic violence victims differs from other crime victims. Rather than ask the question "Why me?", battered women are more likely to wonder "What did I do tonight that set him off?" (Frieze et al., 1987). Once they answer this question, battered women often go to great lengths changing their behaviour in an effort to prevent future violent episodes.

Attempting to change their behaviour is a typical response of battered women (Frieze, 1979; Hilberman & Munson, 1978; Walker, 1978). However, evidence suggests that the behavioural coping strategies employed by victims of domestic abuse are limited. Wirtz and Harrell (1987b) reported that the most common response to domestic violence is staying at home more often (56%), followed by changing phone numbers (23%) and moving residence (21%). Moreover, these strategies do not seem to reduce levels of distress. Wirtz and Harrell examined the relationship between coping methods employed by various crime victims and psychological distress and found that two of the behaviours frequently undertaken by wife abuse victims (changing telephone numbers and staying home more) were associated with elevated levels of short and long-term fear, anxiety, stress and dismay.

Pfouts (1978) has described four behavioural coping strategies that victims of domestic violence can employ to deal with their predicament. She postulated that an abused woman first makes a "cost/benefit" analysis of her current situation and then an analysis of what she believes her circumstances will be like if she opts for the best possible alternative available. The four major coping responses open to battered women are (1) the self-punishing response: the wife blames herself and remains in the relationship, (2) the aggressive response: the wife reacts by using violence against the perpetrator, (3) the early engagement response: the wife actively responds immediately after the first abusive incident, and (4) the reluctant midlife disengagement response: after years of abuse the cost of remaining becomes too high so the wife leaves the relationship. Although Pfouts did not empirically test the relationship between these coping strategies and psychological well being, it appears that the third response (early engagement) would be associated with the least

psychological trauma whereas the first (self-punishing) and possibly the fourth coping response (midlife disengagement) would be correlated with the most psychological sequelae.

As with other victims of crime, when it is provided, battered women benefit from the social support of others. At one time or another most abused women have sought help from therapists, social service agencies, or the clergy (Frieze et al., 1987; Pagelow, 1981). Mitchell and Hodson (1982) have shown that the support offered to these victims can be quite important in terms of helping them cope with the victimization and avoiding future violence.

The reactions of the police to abused women have been demonstrated to impact on women's feelings towards themselves and their willingness to pursue legal action against the perpetrator. Brown (1984) gathered data on 84 abused women and found that those who perceived the response of the police to their assault as negative were more likely to report feelings of self-blame and shame. In other words positive police responses may elevate the self-worth of victims. Furthermore, positive perceptions of the police were related to victims' willingness to lay charges.

Summary

Statistics indicate that a large number of women are subjected to domestic violence. Wife battering is a common problem but often goes unrecognized by professionals. The psychological reactions of battered women are characteristic of post traumatic stress disorder. The sequelae resemble those experienced by rape victims but often last over a longer period (i.e., the attacks frequently recur over many years). Anxiety and depression, increased fears and phobias, recurring nightmares, sleep and eating disorders, disturbed affect, problems with interpersonal relationships and repeated intrusive recollections of the traumatic event are common. Somatoform disorders, drug abuse and suicidal behaviour have also been reported. At the time of writing, no data were available on the incidence of PTSD in this population of assault victims. Children who are raised in homes with domestic violence are also at risk for developing psychological and behavioural problems.

Little empirical research has been conducted on moderator variables. Childhood experiences with abuse, the duration and severity of the assaultive behaviour, behavioural responses such as staying at home more often, poor social support, and the negative response of victim service agencies and law enforcement personnel have all been posited as influencing the psychological impact of domestic violence. Theoretically, learned helplessness along with patriarchal societal attitudes and economic impoverishment best explain why many women remain in abusive relationships for long periods of time rather than escape.

Physical Child Abuse

Although the abuse and neglect of children at the hands of their caregivers is not a phenomenon unique to the twentieth century, it was considered relatively obscure until Henry Kempe's 1962 paper (see Kempe, Silverman, Steele, Droegenmueller & Silver, 1985), in which the emotive term "Battered Child Syndrome" was first used. The paper provided the major impetus for professional as well as public awareness of the existence of child abuse (Gelardo & Sanford, 1987; Lynch, 1985). The battered child syndrome was coined by Kempe et al. (1985) to describe a "clinical condition in young children who have received serious physical abuse, generally from a parent or foster parent" (p. 143).

The battered child syndrome does not necessarily describe the same condition as child neglect, emotional abuse or child maltreatment, which have also deservingly received considerable attention in the literature. Although the effects of neglect, maltreatment and emotional abuse are less "horrifying" than the injuries associated with physical (and sexual) abuse, the long-term impact on the child may be just as detrimental (Iverson & Segal, 1990). The current paper will only review the psychological effects of the syndrome described by Kempe and his colleagues: Battered Child Syndrome.

Statistics

It is commonly estimated that the actual number of child abuse cases far exceeds those identified and treated as such. In Canada it has been gauged that only 25% of child abuse cases are accurately identified (cited in McLaren & Brown, 1989). The exact scope of the problem is difficult to assess due to the absence of reliable data (Gelardo & Sanford, 1987). The definition of what constitutes abuse varies from study to study and the estimates on which the data are based come from a variety of sources, many of which use different reporting criteria (e.g., age of inclusion). Not only parents, but older siblings may be implicated in repeated serious assaults on young children (Tooley, 1977).

Although not always accurate, some U. S. survey statistics are available which serve to underscore the seriousness of physical child assault. To illustrate, in the United States the yearly incidence has been estimated to range from 351,000 to 1.4-1.9 million cases of maltreatment (Gelardo & Sanford, 1987). Straus and Gelles (1986) reported that the incidence of physical abuse in two parent families in 1985 was 1 million. In Canada comparable statistics have not been gathered, although numerous calls for such data have been made (National Clearing House on Family Violence, 1989).

Short and long-term psychological effects

Both Gelardo and Sanford (1987) and Lamphear (1985) have reviewed the literature on the psychological and social maladjustment of children who are physically assaulted and noted their has been relatively little attention given to this aspect of abuse. The vast majority of work has been conducted on factors associated with parental psychopathology,

disturbances in family interaction, the parent-child relationship and predisposing social stressors. Of the studies that have been conducted, very few use the same definition of abuse, hardly any employ matched control groups against which to compare victims, and there is a conspicuous lack of longitudinal research. Lamphear (1985), therefore, concluded that "it is impossible to draw definitive conclusions on the effects of child maltreatment on psychosocial development" (p. 252). Fortunately, these comments notwithstanding, some insights can be gained into the consequences of this offense from the few studies that met Lamphear's criterion and from empirical studies and literature reviews that have been conducted in the time since her article was published.

McLaren and Brown (1989) conducted a recent literature review of the psychosocial problems associated with physical abuse and listed them in order of the number of times they have been cited (see Table 6). They warn, however, that the most commonly reported problems may not necessarily be the most frequently occurring ones but rather they may be the most obvious or the ones most often "looked-for" by researchers and clinicians. Furthermore, it is not clear whether their citations were evaluated methodologically.

Lamphear (1985) screened the studies that have been conducted on the impact of physical abuse before including them in her review. She noted several recurring themes in the literature which she admonishes should be treated tentatively. Based on her review, Lamphear concluded that, compared to children who have not been abused, physically battered youths display the following psychosocial problems in no particular order of frequency of occurrence: noncompliance; tantrums and aggression directed towards both peers and adults; poor peer relationships; social skills deficits; social withdrawal; low empathy; poor school adjustment and academic performance; and behaviour problems.

Iverson and Segal (1990) also conducted a recent review of the literature on the psychological sequelae of child physical abuse. They reported that the reactions most often associated with these victims are aggression and fear. Interpersonally, physically abused children are described as angry, hostile, fearful of others, withdrawn, stoic and aggressive. They have a general inability to derive security and comfort from their caregivers. As these children grow older, their behaviour often appears increasingly aggressive and is more likely to elicit negative or rejecting responses from others (also see Gelardo & Sanford, 1987).

Based on these reviews, it is clear that the psychological and behavioural effects of child physical abuse can be significant. The more serious consequences deserve further discussion.

One of the most commonly reported findings in the literature is that physically maltreated children behave aggressively both towards their peers and their caregivers (Briere & Runtz, 1990; Gelardo & Sanford, 1987; Iverson & Segal, 1990; Lamphear, 1985; McLaren & Brown, 1989; Steele, 1986). For example, young children may bite their playmates, while older children bully other children at school and their siblings. General conduct disorders as demonstrated by juvenile delinquency, truancy, stealing, lying and drug

Table 6.
Childhood psychological and behavioural problems associated with physical abuse †

psychosocial problem	No. of references
aggressive behaviour	12
social impairment	11
low self-esteem	6
developmental language delay	5
low intelligence	5
school problems	5
delinquent behaviour	4
non-compliance	4
excessive compliance	3
depression	3
attachment problems	3
poor emotional health	3
running away	3
passivity	3
hyperactivity	3
role reversal	3
fear	2
sleep problems	2
retarded motor development	2
frustration	2

† adapted from McLaren (1989)

abuse are characteristic of children who have been abused. Reports from inmates of penitentiaries reveal that a significant number were childhood victims of neglect or physical abuse (Steele, 1986). Suicidal and/or homicidal thoughts have also been reported (McLaren & Brown, 1989).

Substantial evidence also exists that physically abused children have poor perceptions of themselves and believe they are not deserving of worthwhile things. Compared to non-abused samples, on standardized tests battered children consistently obtain lower self-esteem

and self-concept scores (Kinard, 1982; Martin & Breezley, 1977; Oates, Forrest & Peacock, 1985; Steele, 1986; Stovall & Craig, 1990). In terms of their emotional display, physically abused children have been found to shown extremes of affect, positive as well as negative. Many of the emotions of abused children appear to be consistent with depression but this relationship needs to be more fully investigated (Gelardo & Sanford, 1987; Iverson & Segal, 1990).

Child physical abuse can led to several cognitive deficits. For example, research on language development has suggested that battered children who have received damage to the language areas of the brain later experience language delays and/or deficits (Appelbaum, 1977). Friedrich, Einbender and Luecke (1983) reported that physically abused children achieved lower scores on a general measure of cognitive ability than a control group of non-abused children. Overall, the evidence indicates that both language and intellectual deficits are associated with physical abuse and that these effects are more pronounced in samples of younger and/or recently maltreated victims (cf. Gelardo & Sanford, 1987; Iverson & Segall, 1990).

Children who have been physically abused have also been shown to display a number of behavioural disturbances. Self-abuse, lying, stealing, truancy, tics, stuttering, drug abuse and unpredictability are common behavioural sequelae (Cavaiola & Schiff, 1988; Gelardo & Sanford, 1987; Iverson & Segall, 1990). When exhibited together in large numbers, they are thought to be indicative of family abuse and thus deserving of special attention.

An important prospective, longitudinal study of the developmental sequelae of child physical abuse was conducted by Egeland and his associates (Egeland & Sroufe, 1981; Egeland, Sroufe & Erickson, 1983). As part of a larger study, they identified 24 physically abusive mothers and gathered information about them, their children and the home environment from the first trimester of pregnancy until the children were five years old. Children of non-maltreating mothers served as the controls. The results showed that, compared to the control group, the physically abused children could not be differentiated until they were 18 months old. After that age the abused children exhibited significantly higher frequencies of anger, frustration and noncompliance, and lower levels of positive affect. From three and a half years to five years of age the children continued to function poorly. They possessed low self-esteem, were more hyperactive and distractible, lacked ego control, were less creative and displayed more negative affect. In preschool, the abused group also had more problems adjusting to that setting than did the children in the control group.

Few studies have been conducted of the long-term consequences of child physical abuse. Most of the longitudinal research follows children through childhood, but not into adulthood. Martin and Elmer (1992) conducted a follow-up study on a sample of 19 individuals who were severely battered as children twenty years earlier. They reported that while some of previously abused children (n=6) had gone on to achieve relatively high academic success (i.e., some college), the majority (58%) were unemployed. Indeed, some

of the respondents had never had a job. Six subjects had a permanent disability and only six individuals did not demonstrate physical of mental health problems. As a group, however, they showed no consistent evidence of emotional difficulties. There was little evidence of overt aggression but resentment and suspiciousness scores were high. Twenty-six percent of the sample admitted having past or present drinking problems. At the time of assessment, the majority of subjects did not seem to be experiencing interpersonal problems with significant others. The authors concluded that there is no simple relationship between early abusive trauma and adult functioning.

Briere & Runtz (1990) administered a series of questionnaires to a sample of 277 female undergraduates to assess the long-term psychological consequences of various types of abuse. They found that different kinds of abuse have both overlapping and specific effects on later functioning. College women who were physically abused as children were unique in so far as they expressed much more aggression towards others. The authors hypothesized that the aggressive behaviour probably derived from their early experiences with abuse. As children they learned that aggression seemed to be an appropriate form of interpersonal behaviour when angry or upset. Summing up the long-term effects of physical abuse, Walker, Bonner and Kaufman (1988) wrote "child abuse may have a profound effect on the entire life of the individual who has been abused and may also affect future generations of that family as well as society at large" (p. 33).

Moderator variables

When the victims of crime are as young as battered children often are, it makes little sense to speak of pre-victimization factors such as beliefs of invulnerability or prior life events that can place children at greater risk for developing subsequent psychopathology. However, this is not to say that events which occur before the abuse happens have no influence on outcomes. The substantial evidence that physical (and sexual) abuse is cyclical (i.e., battered children grow up and batter their own)(cf. Gelardo & Sanford, 1987; Kempe et al., 1985; Spinetta & Rigler, 1972; Steele, 1986; Walker et al., 1988; Wolfe, 1985) necessitates some discussion of the parents of battered children. In a sense, characteristics of parents that place them at greater risk for committing abuse can be considered pre-victimization factors.

Pre-victimization factors. Educational, occupational, economic and social stressors have all been posited as stressors leading to an increased likelihood of child abuse. Although lower SES are over-represented in police reports, statistics indicate that child abuse occurs in all echelons of society. Indeed, data show that most socially and economically deprived parents do not physically abuse their children. However, when abuse does occur in these families, it is more likely to be reported (Gelardo & Sanford, 1987). Thus, the evidence suggests that socioeconomic factors do not account for the occurrence of abuse (Kempe et al., 1985; Spinetta & Rigler, 1972; Zuravin, 1988).

Other stressors that have been shown to be related to the occupance of physical abuse include family size, excess or unwanted children, age at first birth, marital discord and domestic violence (e.g., Gelardo & Sanford, 1987). Alcoholism, sexual promiscuity, unstable marriages and minor criminal activities are also frequently identified (Creighton, 1985; Kempe et al., 1985). Berios and Grady (1991), for example, reported that in about half the cases of domestic violence he studied, children lived in the home where the abuse took place. In 35% of the cases one or more children witnessed the violence and in 10% the children were also the targets of physical abuse.

A large body of literature exists showing that many physically abusive parents suffer from a wide range of psychopathology (see Walker et al., 1988). Gelardo and Sanford (1987) as well as Kempe al. (1985) described the parents of battered children as frequently being of low intelligence and possessing abnormal personalities, sometimes characteristic of psychopathy (antisocial personality disorder). They have been reported to be generally immature, impulsive, self-centred, hypersensitive and short tempered. Spinetta & Rigler (1972) noted that many abusing parents lack warmth, reasonableness and have rigid thought processes. Inadequate or poor impulse control were also identified. Of course, given the cyclical nature of abuse, some of these characteristics might more appropriately be described as long-term effects of physical assault. Only a few abusing parents have been shown to suffer from severe psychosis (Spinetta & Rigler, 1972).

Several authors have suggested that social isolation from the rest of the community may be an important mediator in the relationship between stress and physical abuse (e.g., Gelardo & Sanford, 1987; Seagull, 1987; Spinetta & Rigler, 1972; Zuravin, 1988). Geographic isolation from neighbours, high family mobility and distant extended family ties are all factors that place families at risk.

In sum, Mrazek and Mrazek (1987) identified the presence of the following environmental factors as risk reducing: (1) being in middle to upper class; (2) having educated parents; (3) having no family background of psychopathology; (4) having a support network; (5) having access to good health, educational and social welfare services; (6) having additional caretakers other than the mother; and (7) having relatives (especially grandparents) in the proximity and neighbours available to provide care and emotional support.

Finally, some factors inherent to the child are considered to place them at greater risk for abuse. Predisposing factors that have been reported include low birth-weight and prematurity, extended periods of parent-infant separation following birth and serious neonatal illness (Gelardo & Sanford, 1987; Walker et al., 1988). Through no fault of their own, children who are cognitively or physically challenged can place greater demands on their parents. For example, many mentally handicapped infants require significantly more care which some parents are ill prepared to provide. The time demands and financial burdens can become emotionally overwhelming. If outside help is not available or for some reason, not wanted, this can create a potential crisis situation leading to abuse as a means of coping. In addition, children with behavioural problems such as hyperactivity or attention deficit

disorders may evoke aggressive parental actions as a misguided attempt to correct these problems (Gelardo & Sanford, 1987).

Demographically, younger children are more frequently assaulted. Although battered child syndrome can occur at any age, children under the age of three are most frequently the victims (Gelardo & Sanford, 1987; Kempe et al., 1985). Regarding gender, until they reach adolescence, males are the more frequent targets of physical abuse. Females are more frequently victimized during adolescence (Gelardo & Sanford, 1987).

Crime characteristics. The physical consequences of the beating of a child by an adult vary depending on the force of the attack. More serious effects include mental retardation, cerebral palsy, blindness, impaired vision, epilepsy, skeletal trauma and even death (Dykes, 1986). In their literature review Gelardo and Sanford (1987) estimated that 60 to 70% of physical abuse cases involve bruises and welts. Abrasions, contusions and puncture wounds constitute 20-30% of abuse findings, while burns and scaldings make up 5-10%. Skull and bone fractures are present in 15-20% of recorded cases, 25-30% of surviving abused children suffer from brain damage or neurological dysfunction and 1-25% of children die because of their injuries. Wounds are most commonly inflicted to the face, back, genitalia, feet, palms and buttocks. They often resemble the shape of an instrument (Iverson & Segal, 1990).

As Steele (1986) points out, physical abuse itself does not necessarily cause related psychological and behavioural problems. Most people, as children have injured themselves by perhaps breaking an arm or receiving a burn due to accidental causes and they have not been harmed because of the care and attention they receive from their caregivers. The psychological sequelae of battered child syndrome comes when the injuries are inflicted by someone to whom one looks for love and protection - and there is no escape.

Research into the relationship between the psychological distress and the severity of injuries and duration of violence is limited. The available evidence seems to indicate that receiving more severe injuries, starting at a younger age, and lasting over a longer period of time are associated with the worst outcomes (Erickson & Egeland, 1987; Kinard, 1983; Mrazek & Mrazek, 1987).

Kempe et al. (1985) noted that more often than not, the battered child's general health is substandard as evidenced by poor skin hygiene, multiple soft tissue injuries and malnutrition. In the absence of bone fractures subdural hematoma and failure to thrive are very common. Evidence of subdural hemotoma in infants includes convulsive seizures, fever, irritability, bulging fontanelle (separations between the skull bones which have not yet hardened) or enlargement of the head and clouded consciousness (see Iverson & Segal, 1990). Occasionally, the child is administered an overdose of drugs or exposed to natural gas or other toxic substances.

Although the data are equivocal, it appears that the perpetrator of the physical abuse is more frequently the mother rather than the father or any other caregiver. Two of three

studies reviewed by Gelardo and Sanford (1987) revealed this to be the case. The parents were also found to be, on average, under 30 years of age.

Post-victimization factors. The principle concern in child abuse is the identification of the problem so that remedial actions can be taken to prevent a similar event from happening again (Kempe et al., 1985). In many instances prompt removal of the child from the abusive environment is necessary to remove the immediate threat that additional violence poses to the child's health and life. Kempe et al. (1985) warns that when a child is returned prematurely to his or her parents they are often assaulted again and may suffer worse consequences. Therefore, the bias should be in favour of the child's safety.

Martin and Breezley (1977) warn of some victimization factors that are related to the severity and frequency of symptoms in child who have been physically assaulted. The number of times a child's home changes, a child's sense of impermanence in the present home; the instability of the home; a punitive home and parental emotional disturbance were all found to be related with more symptomatology. Thus, forced removal of abused children can have some serious consequences about which child protection agencies should be aware.

Drawing from the larger literature on child abuse, Mrazek and Mrazek (1987) suggest that there are factors which make some children more resilient to the trauma associated with severe and prolonged abuse. Not all physical abuse victims suffer serious emotional sequelae; some children come through the experience surprisingly well. A number of personal traits, interpersonal skills and life circumstances may help children endure and eventually overcome severe early maltreatment. They are the following: (1) the ability to respond quickly and avoid dangerous situations; (2) precocious maturity; (3) the ability to dissociate oneself from intense affect; (4) the desire to learn about the hazard in one's environment; (5) the ability to foster a support network; (6) the ability to imagine a better life; (7) the ability to make difficult risky decisions; (8) the ability to love and the conviction of being loved; (9) the ability to recognize and acknowledge the competencies of one's aggressor; (10) the ability to cognitively reconstruct painful situations into more acceptable ones; (11) altruism; and (12) optimism and hope (also see Zimrin, 1986).

Summary

All indications are that child physical abuse is more pervasive than official statistics show. Given the methodological inconsistencies in the child physical abuse literature, in addition to the various definitions of abuse, a concise integration of the research findings is difficult. The best available evidence indicates that, compared to nonabused children, child victims of physical assault have several psychosocial problems including noncompliance, tantrums and aggression directed towards both other children and adults. They also have problems with peer relationships, possess social skills deficits, have less empathy, and adjust and achieve poorly in school. Aggression, low self-esteem, cognitive deficits, and behavioural disorders are some of the more serious consequences of child physical assault.

Data are not available on the probability of physically abused children developing these problems.

Research of the long-term psychological sequelae associated with physical child abuse is seriously lacking. However, it is safe to assume that the long-term implications can be significant. Serious intellectual deficits, language delays, interpersonal problems, affective and behavioural disturbances resulting from childhood physical abuse all are likely to interfere with adaptive functioning later in life. The evidence of a cyclical pattern in abuse is adequate proof that the life-long implications can be profound.

Several variables have been shown to place families at risk for child abuse including socioeconomic depression, large family size, unwanted children, marital discord, domestic violence, parental psychopathology, age at first birth and familial social isolation. Premature children, children who are separated from their parents for extended periods of time at birth, children under the age of three and children who are cognitively and/or behavioural challenged are also at higher risk.

Although the research is limited, it appears that physical assaults resulting in serious injury, abuse beginning when the child is very young, and assaultive behaviour lasting over a long period are related to more severe psychological distress. Some children have been shown to be more resilient to the consequences of physical abuse than others. Early intervention by child protection agencies is perhaps the best way to avert long-term psychological sequelae.

Survivor Victims of Homicide

Statistics

Homicide is a major cause of mortality in the United States. In 1985 it was estimated that a murder took place once every 25 minutes (in Rinear, 1988). Among young black men and women it is the leading cause of death. Traditionally, Canadian rates have been much lower. Statistics reveal that in 1990 homicides represented less than 1% of violent crime in this country and only 0.2% of total Criminal Code offenses reported to the police. The national rate was 2.5 per 100,000 which is 3% lower than the previous 10 year average (Statistics Canada, 1991). In addition, over three quarters of homicides and attempt murders in Canada are cleared by charge by the police. The vast majority of murders leave one or more survivors, usually family members who grieve their loss. However, we have no information on their numbers.

Short and long-term psychological effects

A great deal more research attention needs to be directed at the consequences of all crime victims. Yet, perhaps the most neglected group of victims are the surviving family

members of criminal homicide (Frieze et al., 1987). The impact of this form of violence is usually measured only in terms of loss of life. These victims have been referred to by a number of names; secondary victims, covictims, indirect victims, and survivors. The scant information we have obtained indicates that these victims experience profound emotional trauma following the murder of a significant other. Indeed, this group of victims may suffer the most psychological sequelae of all (Amick-McMullan, Kilpatrick, Veronen & Smith, 1989; Resick, 1987b).

The loss of a loved one causes intense emotional reactions, but when the loss is sudden and marked by violence the grief reaction is more profound. In homicide, the victim's life has been deliberately taken in a willful and malicious act (Bard & Sangrey, 1986). The reactions of survivors of homicidal death differ significantly from those of people who grieve the loss of a loved one who died nonviolently (Sprang et al., 1989). The process of mourning for families of murder victims lasts longer, is more intense, and more complex.

Initially, the reactions of relatives to the violent death of a family member were thought to follow specific stages similar to those passed through by others experiencing grief. In this regard the work of people like Lindemann (1944) and Kubler-Ross (1969) was considered to be appropriate. Lindemann, for example, studied the reactions of people who survived a nightclub fire in Boston and identified a bereavement syndrome characterized by somatic disturbances, preoccupation with death, self-blame, hostility and disorganized behaviour. Accordingly it was thought that the grief process consisted of three stages; shock, despair and recovery. The exact number of stages passed through varied across studies but the last stage always represented the resolution of the reaction.

Early investigations consisted primarily of case studies with very small samples of survivors. However, several important findings emerged. Research consistently showed the grief reactions of homicide survivors were deeper, emphasized rage and vengefulness more often and resulted in longer lasting anxiety and phobic reactions (Amick-McMullan et al., 1989). In addition, the reactions of victims were significantly related to the response of those working in the criminal justice system. Prolonged involvement appeared to impede the recovery process.

Although this research provided an extremely important beginning, grief theory was determined to be insufficiently comprehensive to explain the range and depth of homicide victim reactions. Rather than the timely resolution predicted by grief theory, it was determined that the traumatic effects can persist for years and, therefore, are may be more characteristic of post traumatic stress disorder than the process of normal grieving (Amick-McMullan et al., 1989). Stevens-Guille (1992) reviewed the research and suggests that the families of murdered victims encounter all of the identified grief stages and reactions, usually more than once and that many, if not all, also experience symptoms of post traumatic stress disorder.

In many ways the extreme reactions of homicide victims are understandable. Homicide has been described as the ultimate violation that one person can impose on another (Sprang et al., 1989). Bard and Sangrey (1986) suggest it represents the destruction of "the self" and that those who are left to mourn the loss have also been violated. They are "confronted with their own mortality, with proof positive that they may, at any moment and quite without warning, be deprived of their lives" (p. 22). Factors such as the atypical nature of the stressor, its potential for causing significant distress in almost everyone, its departure from normal human experience, and its occurrence as a result of human design have been suggested to account for its profound impact on survivors (Rinear, 1988).

Amick-McMullan et al. (1989) have noted a general agreement among researchers concerning the actual symptoms reported by survivors of homicide. Studies have found similarities in terms of survivor victims' cognitive, affective, physiological and behavioural reactions. Within the cognitive realm, intrusive and repetitive thoughts including nightmares as well as recollections about the murder are commonly reported. Affect is dominated by rage, terror, numbness and depression. Physiologically, disturbances in sleep and appetite, increased heart rate, headaches, gastrointestinal upset and increased startle responses were frequently noted. Finally, behavioural reactions included self-protective activities such as social withdrawal, the avoidance of anything related to the murder, interpersonal changes, and a tendency to try to hunt for the killer. These clinical sequelae reportedly last for years (Rynearson, 1984).

Burgess (1975) has suggested that the data on the reactions of survivor victims support the existence of a "homicide-trauma syndrome". She interviewed nine families of homicide victims and determined that the syndrome includes an acute impact stage triggered by the sudden violent death, followed by a long-term reorganization process resulting from the socio-legal demands of homicide. Physical signs and symptoms commonly noted in the first stage were insomnia, sleep pattern disturbances, headaches, chest pain, heart palpitations and gastrointestinal upset. Later, as they tried to deal with the socio-legal issues, the survivors became preoccupied with thoughts about the victim, suffered dreams and nightmares, phobic reactions and identified with the tragedy. Guilt and self-blame over how the event might have been avoided were also common.

One of the largest studies of the psychological sequelae and associated stressors experienced by parents whose children were murdered has been conducted Rinear (1988). She presented data on 237 parents of child homicide victims and found that their symptomatology was more characteristic of post traumatic stress disorder than grief reactions. Symptoms/reactions consistent with a PTSD diagnosis were recurrent and intrusive recollections of the event, recurrent dreams of the crime, markedly diminished interest in one or more significant activities, feelings of detachment and estrangement from others; constricted affect, sleep disturbances, avoidance of activities that aroused traumatic recollections of the murder, memory impairment and trouble concentrating, and intensification of symptoms by events that symbolized or aroused traumatic recollections of the crime. PTSD symptoms were reported to have begun within one week of the child's

death and last for one or two years. Similar results were reported by Masters, Friedman and Getzel (1988).

Amick-McMullan et al. (1989) gathered information from 19 survivors, 60% of whom were the parents of a murdered victim. On average, 2.5 years had elapsed since the crime. They reported a high degree of psychological distress among their sample. On one measure, 64% of the respondents were experiencing sufficient psychiatric impairment in the areas of depression, somatization, anxiety and phobic anxiety to warrant further assessment and treatment. All of the victims reported some degree of event-related symptomatology characteristic of PTSD. Compared to persons who had experienced the death of a parent, significant others, and a sample of rape victims, the homicide survivors reported the highest frequency of trauma.

Another study to look at the incidence of PTSD in survivor victims of homicide was conducted by Bard, Arnone and Nemiroff (1986). Using records from the New York City Medical Examiner's office, they located a sample of 40 survivors two to five years after they lost a family member. In the first year after the death, more than half the respondents showed evidence of PTSD and one person was reported to be experiencing PTSD symptoms four years later. In addition to this psychopathology, two thirds (17) of the homicide survivors reported having had somatic disorders such as digestive problems, physical illness, or severe headaches during the first 6 to 12 months after the death. Seven were experiencing these problems at the time of the interview.

A type of survivor victim deserving of special consideration are children who witness parental murder. Palombo (1981) has argued that traditional definitions of grief are not necessarily appropriate for children. The cognitive development of children (i.e., their ability to comprehend the abstract nature of death) does not fully develop until early adolescence. Their ability to grasp the concept of death can, in turn, have consequences for the manner in which a child can cope with the event. All experiences do not necessarily have the same meaning for children so parental loss due to murder may not be always result in symptomatology or permanent scarring.

Empirical research on child survivors of homicide has been limited (see Lebovici, 1974; Malmquist, 1986; Pynoos & Eth, 1984; Schetky, 1973). Lebovici (1974) observed a sample of children who had witnessed the violent death of one of their parents and was surprised to note the lack of visible effects the event had on some of the children. Malmquist (1986) examined sixteen young children between the ages of five and ten who witnessed a parental murder or attempt murder and reported that although there was a great deal of diversity in response, all of the children easily met the diagnostic criteria for post traumatic stress disorder. He was also struck by the resilience of some of the children. Finally, Pynoos and Eth (1984) followed 40 child witnesses from the period within weeks of the event through to the criminal proceedings. Eighty percent of their sample were assessed as warranting a PTSD diagnosis. Depending on the age of the child witness, different post traumatic behavioural responses were observed. Preschoolers were most likely to appear

withdrawn, subdued or mute and were particularly vulnerable to anxiety and sleep disturbances. School-age children, on the other hand, tended to exhibit a wider range of responses. Normally quiet, well-behaved children turned irritable, rude and argumentative, whereas otherwise exuberant children became passive, inhibited and unresponsive. Compared to younger children, they complained of physiological symptoms like headaches and stomach upset. School performance dropped across the board. Adolescent reactions were reported to resemble those of adults.

Moderator variables

As mentioned, the research into the effects of homicide on surviving family members is limited. Far less work has been conducted on moderators variables. Thus, rather than discuss the current research in terms of pre-victimization factors, crime characteristics and post-victimization factors, it makes more sense to combine the categories. This does not imply that these three groups of factors are not important with regard to this offense, but rather insufficient research has been done to warrant separate discussion. Furthermore, the limited research that has been conducted in this area has mostly employed small, nonrandom sample sizes which reduces the confidence one can have in the results.

With regard to demographic buffer variables, Amick-McMullan et al. (1989) found that symptomatology was not related to gender. Sprang, on the other hand, reported that men have higher levels of unresolved grief for murder victims than females (cited in Sprang et al., 1989). The suggestion has been made that religious beliefs, ethnic factors and prior experiences with death moderate the impact of murder (Sprang et al., 1989), but no empirical evidence exists to support, or refute, this claim. With regard to offender/victim relationship and the time since the homicide, they both have been demonstrated to be unrelated to outcomes (Amick-McMullan et al., 1989). Rynearson (1984) suggests bereavement is influenced by the offender/victim relationship, the capture of the perpetrator and the recovery of the body. Again, though, no empirical support is provided. The only study to report empirical data on the role of attributions, revealed that the parents of murdered children who engage in self-blame have more severe and longer lasting bereavement symptomatology (Rinear, 1988). Masters et al. (1988), on the other hand, suggest that self-blame among homicide survivors acts as a coping mechanism and a means of coming to terms with the apparent loss of control. Finally, the cognitive age of children and their inability to comprehend the concept of death may buffer the loss of a loved one. It has been suggested that younger children may be more resilient to the long-term effects of witnessing the murder of a parent (Palombo, 1981). Some evidence of this was provided by Pynoos and Eth (1984).

A variable that studies have consistently found to moderate the degree of impact experienced by survivor victims is the response of the criminal justice system (Bard & Connolly, 1983; Masters et al., 1988). Sprang et al. (1989) have suggested that "family members of murder victims are victimized twice: first by the criminal and second by the system" (p. 162). Murder investigations can be prolonged, police have been accused of

being insensitive, murder cases often take a long time to come to trial and when they do they can be harsh reminders of the trauma all over again. Amick-McMullan et al. (1989) reported a highly significant correlation between criminal justice satisfaction and the outcome measures of distress they administered homicide survivors. Similar findings were reported by Bard and Connolly (1983). If homicide survivors set the help they need from those in the formal system, their recovery process is facilitated. On the other hand, the victim perceives rejection on the part of others, they can receive what Symonds (1980a) called a *second injury* - one that could have been avoided.

Summary

Although murder is a relatively uncommon criminal offense, its effects can be severe for the surviving family members. The psychological symptomatology is consistent with post traumatic stress disorder and is experienced by the vast majority of survivors. Approximately three-quarters develop the disorder following the violent loss of a significant other. The effects can be expected to last for several years.

Witnessing the murder of a parent an even more rare event and, therefore, the reactions of children do not easily lend themselves to generalizations that can withstand critical evaluation (Malmquist, 1986). However, it is hard to imagine a more traumatic experience than to witness the homicide of one's parents. Indeed, the limited research conducted on this subject confirms that the reactions can be wide ranging, and depending on the cognitive development of the child, the psychological sequelae severe. Upwards of 80% of children who witness the murder of a parent can be expected to subsequently develop PTSD.

With regard to moderator variables, not enough research has been conducted to make many conclusive statements. First, it appears that the psychological effects appear to differ depending on the cognitive development of a child who witnesses the death of a parent. While very young children can still experience loss, they do not completely understand the complexities of death and thus may be more resilient to subsequent long-lasting trauma. Second, a great deal of evidence exists that the sympathetic response of those working in the criminal justice system has a significant influence on the response of survivor victims. Many authors suggest that law enforcement personnel, lawyers, judges and court reporters need to be more responsive to the needs and concerns of the families of homicide victims to ensure they do not relive the profound trauma and grief associated with the violent loss of a loved one.

Conclusions and Discussion

Although the physical, psychological and financial hardships that many victims of crime experience are often profound, they have not received commensurate support from health and social services. Irvin Waller (1989), a criminologist and outspoken victim

advocate, has noted that "compared to more than $100 spent each year per Canadian to try to catch, convict, and incarcerate offenders, we spend less than a dollar on all criminal injuries compensation and rape-crisis centres. If we added to this, all expenditures on transition homes for battered wives and crime-victim support programmes, we still devote less than $2 per Canadian to specific services for victims" (p. 253). Recent federal legislation and the successes of provincial Victim Assistance Committees, such as the one in Manitoba, have undoubtedly improved the situation but many victims of crime continue to suffer unnecessarily because of neglect.

Clearly a great deal more research attention needs to be directed at the behavioural and psychological consequences of criminal victimization. The pool of knowledge about the effects of sexual offenses has grown significantly over the last twenty years but relatively little attention has been paid to the victims of crime discussed here. Based on current information, we know that the distress caused by these offenses can be severe. Battered women, survivor victims of homicide, victims of kidnapping, torture and terrorism, and children who are physically beaten by their caregivers all have been shown to experience symptoms characteristic of post traumatic stress disorder. Many robbery and assault victims also reportedly experience many of these symptoms. A minority can expect to receive the diagnosis. The long-term consequences can also be severe if intervention and treatment are not provided.

A general model of moderators that can influence the reactions of all crime victims has been proposed. Given that research has shown the reactions of people who are criminally victimized are qualitatively similar, previctimization variables such as demographics and prior life events, characteristics of the offense like the degree of violence perpetrated, and postvictimization variables including social support, attributions and behavioural coping strategies, may all play a role buffering the effects of crime. The research on the role of these variables as they apply to the offenses discussed in this paper corroborates their importance. Again, substantially more work needs to be done in this domain.

Great progress in research has been made, but our understanding of what constitutes a serious offense from the perspective of the victim remains limited. One can conclude that any criminal code offense has potentially severe consequences on victims depending on factors like their prior life experiences with traumatic events, the severity of the injuries they receive, and the methods they take to overcome the effects. In the absence of additional research, the prudent course of action is the continued support of victim support agencies. The value of their work cannot be understated.

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Footnotes

1. The reader is referred to Hanson (1989, pp. 3-8) for a general discussion of the nature of psychological adjustment and trauma as it pertains to criminal victimization.

2. The reader is referred to Hanson (1989) for a complete review of the psychological impact of sexual offenses on victims.

3. Maguire and Corbett (1987) combined robbery and assault victim responses in their analyses. Thus precise estimates of the percentage of assault victims reporting these symptoms are not possible.