1. **INTRODUCTION**

In principle, it is prudent to follow empirically-validated treatment protocols. In practice, the lives and circumstances of clients are often far more complex than clients in research validation samples. Depending on the nature of factor producing complexity and differing elements, an entirely different treatment plan might be required and the expected length of treatment may need to be increased. At times treatment for the crime-caused condition may need to be suspended until other conditions are well-managed or resolved.

Many different factors can contribute to the complexity of a case. Some examples include: multiple Axis I disorders, the presence of Axis II disorders as well as increased psychological stress and/or decreased social support. Some specific conditions include the presence of: chronic pain, traumatic brain injury, alcohol and other substance abuse, pre-crime psychopathology in Axis I as well as Axis II, higher than average psychosocial stressors and lower than average psychological support.

It is important that the clinician not only diagnose those conditions caused by a crime, but also the conditions exacerbated by the crime as well as those conditions unrelated to the crime. As in all of the VCCB Guidelines, the diagnoses should be multi-axial in accordance with the current *Diagnostic and Statistical Manual* published by the American Psychiatric Press.

Research has indicated that the majority of crime victims do not require more than six sessions if the sessions are therapeutically appropriate. To obtain VCCB benefits beyond the six initial sessions, the client must have a crime related psychiatric disorder as defined by the current edition of the *DSM* and must demonstrate capacity and benefit from the proposed treatment plan.

VCCB awards are for losses incurred as a direct result of certain violent crimes. The VCCB is not required by AS 18.67 to authorize or to make awards for treatment of co-morbid conditions that were not caused or exacerbated by the crime. However, if there are co-morbid conditions which pose a barrier to rehabilitation and recovery, and treatment is likely to promote recovery in a cost-effective manner, authorization for limited and focused treatment may be granted. Treatment of non-crime related conditions might not require the resolution of those conditions, but simply the management of them, so that they no longer pose a significant barrier to recovery from the crime related condition.
2. CO-MORBID FACTORS: ANGER

Anger is a common symptom in victims of trauma (Riggs, et al., 1992). Some studies have indicated that feelings on anger predict chronicity in post-traumatic stress disorder. There is also some evidence that preoccupation with anger interferes with successful outcome of some types of psychotherapy (Foa, et al., 1995). Recent research has helped to clarify some of the conceptual confusion that has stymied attempts to define and delineate different types of dysfunctional anger reactions. Research has also demonstrated successful intervention protocols based on the cognitive-behavioral models, particularly the stress inoculation model (SIT). Finally, research has demonstrated that some popular treatment ideas and recommendations may not only fail to help resolve anger, but may actually aggravate anger problems.

PRINCIPLES OF DIAGNOSIS AND TREATMENT

Differential diagnosis is required to develop an appropriate treatment plan for anger problems. Jerry L. Deffenbacher (1996) commented that the Diagnostic and Statistical Manual of Mental Disorders does not recognize anger as constituting any discrete syndrome, but it is an important symptom in a variety of disorders. Some disorders may require or benefit from medications, some may respond to psychosocial procedures and environmental modifications alone.

- Anger associated with aggression and violence will first need to be safely contained.

- Psychiatric consultation for medication management should be considered when anger is intermittently explosive, part of a bipolar disorder or reflecting an organic mood disorder. Other conditions in which anger is present may also benefit from medications. In general, when in doubt, consult.

- With generalized anger, consider cognitive-behavioral models of intervention (Novaco, 1975).

- When aggression and violence are appropriately contained and anger is a significant factor in a marital or couples relationship intervention models as developed by John Gottman and Neil Jacobson may have particular merit (Gottman, 1995, Jacobson, 1996).

- Expression oriented therapies appear to have no more than anecdotal support. A variety of clinical investigations suggest that expression or catharsis oriented treatments may reinforce subsequent episodes of anger and angry ruminations. With children, SIT and Aggression Replacement Therapy have shown significant success (Goldstein and Glick, 1987). Deblinger and Heflin (1996) have some useful recommendations for
managing anger episodes in child victims of sexual abuse. Expression-oriented therapies may result in particularly hazardous outcomes in children (Feshbeck, 1956).

REFERENCES


3. CO-MORBID FACTORS: ANXIETY

INTRODUCTION

Anxiety can be a symptom of a number of mental disorders including other Axis II and Axis III disorders in the DSM-IV (1994). It is also a domain of Axis I disorders in the DSM-IV including: Agoraphobia, Panic Disorder Without Agoraphobia, Panic Disorder With Agoraphobia, Agoraphobia without History of Panic Disorder, Specific Phobia, Social Phobia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Anxiety Disorder Due to a General Medical Condition, Substance-Induced Anxiety Disorder, Anxiety Disorder Not Otherwise Specified, as well as the Posttraumatic and Acute Stress Disorders. In light of the complex nature of anxiety, this guideline intends to provide a general outline of how to proceed with clinical decision-making and care. It will also provide a selected bibliography of widely available publications for the professional audience as well as the general public including crime victims.

DIFFERENTIAL DIAGNOSIS

Anxiety that persists following a crime trauma, and the initial response to contain any crisis and provide education and support will need to be carefully evaluated. The clinician should evaluate the crime victim on all five axes of the DSM-IV using the principles of differential diagnosis. Such a procedure will help to assure that emotional symptoms caused by general medical disorders or substance use disorders are appropriately referred and treated. It will assure that symptoms of long-standing personality traits and personality disorders are not confused with acute reactions to trauma. Finally, it will assure that the specific nature of any Axis I anxiety pathology is sufficiently delineated so that appropriate treatment can be instituted.

TREATMENT

The American Psychological Association task Force on Promotion and Dissemination of Psychological Procedures (1995), has identified several empirically validated treatment protocols for anxiety disorders. An update of the task force added empirically validated treatments. The following list reflects a compilation of both documents for those treatments passing empirical validation standards to the “well-established” and “probably efficacious” level:

<table>
<thead>
<tr>
<th>Generalized Anxiety Disorder</th>
<th>Panic Disorder with and without Cognitive agoraphobia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behavior Therapy</td>
<td>Cognitive Behavior Therapy</td>
</tr>
<tr>
<td>Applied Relaxation</td>
<td>Applied Relaxation</td>
</tr>
<tr>
<td>Simple Phobia</td>
<td>Obsessive-Compulsive Disorder</td>
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<td>-----------------------</td>
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<tr>
<td>Exposure Treatment</td>
<td>Exposure and response-prevention treatment</td>
</tr>
<tr>
<td>Guided mastery</td>
<td>Cognitive Therapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agoraphobia</th>
<th>Social Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure treatment</td>
<td>Group cognitive therapy for social anxiety</td>
</tr>
<tr>
<td></td>
<td>Systematic desensitization</td>
</tr>
</tbody>
</table>

As indicated in other guidelines, these therapies have withstood the ordeal of empirical validation. Many other psychotherapeutic approaches may ultimately prove to be useful when they are submitted to appropriate empirical inquiry. The preceding review details psychological treatments only and doesn’t consider the role of medications. There are a number of complex issues when using medication to treat anxiety-based disorders. In general consultation with a professional who has obtained specific training in the use of psychotropics, such as a psychiatrist or psychiatric ARNP or clinical psychiatric pharmacologist is best. Symptom targets must be identified, appropriate medications (for instance, medications classified as antidepressants may have a significant role in reducing intrusive ideation in PTSD and in managing Obsessive-Compulsive Disorder) must be determined, as well as dosage and duration of treatment. In the section below, indication for medications and other psychiatric issues are reviewed.

**REFERENCES**


**RELATED READING**


CO-MORBID FACTORS: DRUG AND ALCOHOL ABUSE

There are several psychiatric disorders (Major Depression, Anxiety, Post-Traumatic Stress Disorder [PTSD] and Substance Abuse) that commonly occur in combination after a severe stress, including the stress of a crime. Substance abuse whether it precedes a crime, is exacerbated by crime victimization or begins as a consequence of crime victimization, can interfere with the resolution of the crime trauma. Recent studies have shown a particularly potent and maladaptive combination of PTSD and Substance Abuse in some crime victims. To understand the problem of substance abuse in crime victims we must begin by understanding how it is related to trauma and PTSD.

RELEVANT RESEARCH

Drug and alcohol abuse is strongly associated with PTSD. Stewart (1996) presents a critical review of over 300 clinical studies that demonstrate a highly positive correlation between trauma, PTSD and alcohol abuse.

- Alcohol and drug abuse is the most prevalent of all psychiatric disorders in the United States – 16% of the population has this disorder.
- Alcohol abusers report three times as much trauma as non-drinkers.
- Studies show a much stronger association with PTSD and alcohol abuse than with trauma exposure alone.

- PTSD signs and symptoms preceded the development of alcohol abuse suggesting that PTSD somehow promotes abuse.

- Studies show a high degree of co-morbidity between PTSD and alcohol abuse – 40% to 70% of adult subjects with PTSD will also have a diagnosis of alcohol abuse.

Longitudinal studies have shown that the PTSD disorder preceded drug and alcohol abuse. Drugs and alcohol may be abused as a maladaptive effort to self-medicate – to moderate the traumatic signs and symptoms of the trauma. Some individuals are incapable of coping with the intense fear and intrusions of flashbacks and nightmares, which interfere with sleep; thus, use of drugs or alcohol as a tranquilizer or hypnotic is a short-term solution that may introduce a long-term problem. Abruptly discontinuing drugs or alcohol after several weeks of daily use will create a “rebound” in which the central nervous system is suddenly free of the inhibiting effects of whatever substance has been abused. That will begin an intense resurgence of the trauma responses that reinforces the need for continual abuse. When this cycle of abuse to control the mental distress of trauma becomes persistent and maladaptive, it is difficult to interrupt because it has now become the primary way that the victim can calm the mind from the mental effects of crime.

MANAGEMENT AND INTERVENTION

Recently, the American Psychiatric Association published guidelines for the management of substance abuse problems based on comprehensive reviews of the current literature (APA, 1996). The guidelines acknowledge both the diversity of clinical conditions and the diversity of people who have substance abuse problems. While specific clients and problems vary, in general, treatment should be preceded by an assessment phase that is oriented both to differential diagnosis and the development of a treatment plan. The first step in treatment may be to help the person through the detoxification and withdrawal process. Depending on the substance abused, medication may play a therapeutic role. Treatment will need to include relapse prevention. Treatment providers may include trained professionals as well as volunteer support groups.

PRELIMINARY STRATEGIES FOR INTERVENTION

Crime victims, and those who provide support services to them, need to be aware of the very basic interactive effects of trauma, PTSD and Substance Abuse. Education will bring a recognition and identification of crime victims presenting with these disorders and their maladaptive combination.

There are well established treatment approaches for Substance Abuse; these interventions should be offered before the crime specific intervention is implemented. If the provider
is unable to provide these services to the client, he/she should refer the client to the appropriate treatment services. In some cases, clinical service may require the simultaneous management of PTSD and Substance Abuse. While management of the Substance Abuse will take priority, the treatment of underlying PTSD should begin when the victim has stabilized since untreated PTSD creates high risk for relapse of the Substance Abuse. There are no controlled studies of victims with these combined disorders to guide us in “staging” intervention specific for PTSD or Substance Abuse. In the absence of controlled studies, it would be appropriate to offer comprehensive and flexible clinical services for both, instead of an “absolute” protocol for one.

CONTRINDICATIONS

Some trauma specific interventions are contraindicated with clients who are currently abusing alcohol or drugs. Specifically, therapeutic interventions involving exposure components may be too stressful or overwhelming for crime victims who are currently abusing, as well as those who have recently achieved sobriety but are still at risk for relapse. Leading researchers in rape trauma and its treatment (Foa & Rothbaum, 1998), explain that a client abusing alcohol or drugs will most likely need to receive treatment for her substance abuse or dependence before she will be ready to deal with her assault. They strongly discourage using the prescribed trauma specific techniques with clients who have current substance abuse disorders and they recommend at least 90 days of sobriety before treating assault-related issues. Resick and Schnicke (1996) support this recommendation and do not advocate the implementation of Cognitive Processing Therapy (CPT) with someone who is currently abusing alcohol or drugs, nor for someone who is fragile in regard to sobriety. However, CPT can be implemented with clients who are comfortable with their sobriety and understand the importance of addressing strong emotions in therapy (Resick & Schnicke, 1996).

SUMMARY

In light of the current literature, substance abuse problems appear to take priority in treatment. Some issues may be dealt with concurrently by a different therapist than the one providing substance abuse treatment, while other issues such as PTSD may require a significant period of sobriety before therapy can be reasonably expected to be successful. Like any other mental health condition, substance abuse problems should be carefully diagnosed and assessed. A professional treatment plan should be developed on the basis of that diagnosis and assessment. The guidelines set by the American Psychiatric Association (1996) are based on a thoughtful and comprehensive review of the practice literature. While these guidelines were specifically developed to assist the practice of psychiatry, all clinicians no matter what their health-care credential would be wisely guided by them.

Finally, it should be emphasized that this attention and service for psychiatric disorders with crime victims is viewed as crime related. PTSD and Substance Abuse are common responses to the trauma of crime and shall first be viewed as secondary effects of the
horror and helplessness forced upon victims. Recovery for victims cannot begin unless our understanding and service is based upon this compassionate insight.

REFERENCES


RELATED READING


RESOURCES
Children’s Hospital in Boston, MA has developed a program (Advocacy for Women and Kids in Emergencies (AWAKE) that serves battered women who also have substance abuse problems. This program offers the traditional services of counseling,
legal advocacy and emergency housing as well as drug and alcohol recovery services.

AWAKE Children’s hospital, 300 Longwood Avenue, Boston, MA  02115. Phone (617) 355-7979.


1. CO-MORBID CONDITIONS: SOMATOFORM DISORDERS

Persistent, often crippling physical complaints for which there is no demonstrable medical cause are a frequent and in some cases solitary consequence of traumatic events. Headaches, stomach and bowel problems, muscle and joint pain, fatigue and malaise, respiratory, cardiovascular, and genito-urinary complaints, and unexplained neurological problems are a few of the symptoms clusters grouped within the general diagnostic category of somatoform disorders. Women and children are more commonly affected than men. Some cultural groups tend to express their psychological distress more frequently in the form of the physical symptoms of somatoform disorders. Extensive medical evaluations and even surgery can complicate and delay appropriate treatment for this group of patients.

If a somatoform disorder is suspected, practitioners are encouraged to consider the following approach. The patient’s symptoms should be acknowledged, and the patient reassured that her experience of physical suffering is believable and real. In the absence of a likely medical cause, symptoms may result from physical responses to the stress of her emotional injuries. As the stress is reduced, symptoms may improve. As treatment proceeds, the therapist remains interested and concerned about the course of the physical symptoms without letting them become the focus of treatment. Communications between the therapist and physician caring for the physical symptoms can also facilitate treatment.