To help patients who have been the victims of violent crime or who have lost loved ones to homicide, psychotherapy must emphasize both concrete, practical helping strategies as well as subtle, reconstructive and integrative modalities. This article reviews the literature on psychotherapy of crime victims and offers recommendations for helping adult and child survivors recover from the traumatizing effects of human malice.

Perhaps more than most traumas, violence perpetrated by our fellow human beings robs us of our sense of a safe and secure world. For many Americans today, violent crime is the overriding social and political issue (Bidinotto, 1996; Budiosky, Gregory, Schmidt, & Bierck, 1996; Kirwin, 1997; Schlosser, 1997). For many crime victims, effective psychotherapy may be the only means to overcome the psychological disability caused by interpersonal violence. In this article's description of the various roles of psychotherapists in facilitating the recovery from violent crime, the term crime victim should be taken in its descriptive sense only to mean the unwilling recipient of another's unlawful and malevolent act.

The U.S. Department of Justice estimates that rapes, robberies, and assaults account for 2.2 million injuries and more than 700,000 hospital days annually (Bureau of Justice Statistics, 1993). In some populations, as many as 40 to 70% of individuals have been exposed to crime-related traumas sufficient to meet diagnostic criteria for posttraumatic stress disorder, or PTSD (Miller, 1994, 1998a), and many individuals have been multiply exposed to such extreme stressors (Breslau, Davis, Andreski, & Peterson, 1991; Norris, 1992; Resnick, Kilpatrick Dansky, Saunders, & Best, 1993). Except for rape, men are assaulted under the same kinds of situations as women, but it may be more difficult for a man to report an assault for fear of shame, ridicule, or disbelief (Saunders, Kilpatrick, Resnick, & Tidwell, 1989).

In addition to PTSD, other diagnosable psychiatric syndromes may be seen following criminal assault. Depression, anxiety, and substance abuse are common psychological disorders found in victims of robbery, rape, and burglary (Falsetti & Resnick, 1995; Frank & Stewart, 1984; Hough, 1985), and a high proportion of panic attacks trace their onset to some traumatically stressful experience (Uhde et al., 1985). In follow-up studies, approximately 50% of crime-induced PTSD cases persist in a chronic course after 3 months (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992), and clinical experience suggests that such traumatic effects may persist in some form for years, decades, or even a lifetime.

Crime can also affect those not directly assaulted or killed. When a family member has been murdered, surviving family members may suffer from intrusive images of what they imagine the scene of their loved one's death to have been, especially if they were not present at the time of the death (Falsetti & Resnick, 1995). Criminal assault survivors may be scapegoated and blamed for their attack by family members who seek to distance themselves from the contagious taint
Psychosocial and Legal Treatment Strategies for Crime Victims

As with trauma patients generally, the best immediate help is often the most practical and self-empowering. Much aid to crime victims is not what would ordinarily be considered "therapeutic" from a clinical point of view, but involves providing down-to-earth, practical assistance in matters related to coping and recovery (Miller, 1998a).

Self-Help

Therapists can assist patients in developing their own front-line coping resources by directing them to self-help groups and support organizations (Brown, 1993). If patients cannot find a good local group, direct them to the national victims' rights organizations that pertain to their specific needs, or call one of the two national umbrella victims-rights groups: the National Organization for Victim Assistance (NOVA) or the National Victims Center.

Therapists should also prepare crime victims to deal with their own responses and the reactions of others. When people ask patients how they are doing, encourage them to answer honestly, albeit diplomatically, not always to say, "Fine." Within certain limits, such as casual greetings, patients need not be afraid to let others—especially close friends and family members—know how they really feel. The line between forthright self-disclosure and immoderate spewing is often a delicate and shifting one, however, and therapists may have to assist patients in role-playing appropriate responses to questions by others. Also, patients should understand when they can self-protectively decline to elaborate on their emotional states in response to questions that may have less benign motivations (i.e., from people who derive gratification from hearing about the patient's ordeal).

In many cases, talking with a true friend or with other survivors of crime can be at least as helpful as formal psychotherapy. Patients should let their emotions emerge at their own pace. They should be reassured that it is acceptable to feel a little sorry for themselves, as long as this does not interfere with adaptive coping efforts. They should try not to let themselves be confused by other people who tell them "how well you are coping" (Brown, 1993).

Victim Support Services and the Criminal Justice System

Victim services, in one form or another, now exist in all 50 states, but budgetary considerations typically restrict the range of services offered. The victims most frequently targeted first for assistance programs are sexual assault victims, domestic violence victims, and children. NOVA has developed a generic model of victim services that contains three major components: (a) emergency response at the time of the crisis, (b) victim stabilization in the days following the trauma, and (c) resource mobilization in the aftermath of the crime (Young, 1988).

All too commonly, attitudes and beliefs regarding the criminal justice system are sorely challenged following violent crime experiences. Victims and family members may find the legal maze intimidating. Interacting with criminal justice representatives may become a traumatic reminder of the painful and humiliating crime experience. Victims often fear the social stigma associated with media reporting, being questioned and disbelieved, loss of personal control, or even revenge by the perpetrator or his allies. Even when victims decide to press charges, ideal images of swift justice can quickly dissolve as legal proceedings drag on for months or years. In response to this, a movement promoting the establishment of rights for crime victims has developed during the last two decades (Freedy, Resnick, Kilpatrick, & Dansky, 1994).

Studies have shown that the prevalence of PTSD is higher among victims who wade through the criminal justice system than among crime victims in general (Freedy et al., 1994). Crime victims most likely to develop PTSD are those whose suffering is associated with violent crimes, such as physical or sexual assault or homicide of a loved one, or who were in terror for their lives during the criminal assault. Support services for victims, including psychological counseling, are typically meager, however. A prevalent attitude among law enforcement agencies seems to be that solving cases takes priority, while the needs of the victim are secondary. Direct clinical experience (Freedy et al., 1994), however, demonstrates that humane treatment of victims and their families can foster optimum cooperation with the criminal justice system. This in turn may facilitate an in-
crease in reporting of crimes and lead to quick and successful closure of cases and prosecution of offenders.

Freydy et al. (1994) examined the prevalence of PTSD and victim service utilization among crime victims and family members recently involved in the criminal justice system. About one-half of the participants met PTSD diagnostic criteria during their lifetimes. Females were overrepresented among victims of violent crimes such as homicide and sexual assault. Victims of the violent crimes—who sustained physical injuries, who perceived that they would be seriously injured, and who perceived their lives to be threatened—were more likely to suffer from PTSD than victims without these characteristics. While most subjects believed that the criminal justice system should provide a range of victim services, including counseling and psychotherapy, most reported access to such services to be inadequate. The implication is that crime victims involved in the criminal justice system are at risk for developing PTSD, which is rarely addressed by mental health professionals due to inadequate access to healthcare services.

Young (1988) has provided a model for victim assistance in criminal proceedings. Therapists should familiarize themselves with the regulations and protocols in their individual jurisdictions in order to help their patients negotiate the legal system. This includes providing information about trial proceedings, helping to access victim and witness programs, supporting victim input to plea bargaining and sentencing, helping the victim prepare a victim impact statement, pursuing civil restitution, and dealing with the aftermath of the trial. The idea is not for the psychotherapist to intrude in the legal proceedings, but to provide emotional support and practical savvy to a patient who may be overwhelmed by the ordeal of going to court and seeking justice.

Psychotherapy of Crime Victims

Early treatments for crime victims were based on crisis intervention models that focused on helping victims deal with the immediate aftermath of violence. With the recognition of PTSD as a primary disorder following crime victimization, the treatment of crime victims has focused on alleviating its symptoms (Falsetti & Resnick, 1995). These can include: (a) emotional numbing alternating with heightened arousal; (b) intrusive reexperiencing in the form of traumatic flashbacks or nightmares; (c) avoidance of situations reminiscent of the trauma; (d) emotional constriction and interpersonal distancing; and (e) impairment in concentration, memory, or other cognitive functions (Miller, 1994, 1998a). Furthermore, there is a need to develop treatments to address the concomitant problems of substance abuse, depression, panic disorder, and family dysfunction.

Crisis Intervention and Emergency Psychological Aid

For most crime victims whose lives were relatively stable before the crime, the first intervention should consist of crisis intervention-type brief therapy. The goal should be to help the patient cope with the impact of the crime itself and find ways to deal with the aftereffects, such as overwhelming loss, relationships with friends and family, and the responsibilities of work and child care. At the end of this phase of therapy, the patient should have some sense of empowerment. Although the patient's life has been altered by the event, he or she should strive to cope with what has happened and reasonably face what lies ahead (Brown, 1993).

In general, crisis intervention is an active and direct approach that by its very nature is short-term (Everstine & Everstine, 1993; Gilliland & James, 1993; Yassen & Harvey, 1998). Information is provided about the likely course of reactions, and these reactions are normalized to assure victims that they are not “going crazy.” Victims are encouraged to talk about what happened and to express their feelings about it. Patient concerns, such as the personal meaning of the crime, whom to tell, and concerns about others' reactions, should also be addressed. Basic resources, such as food and shelter, should be inventoried, and necessary community resources should be accessed and mobilized. Crisis intervention also involves clarifying and reinforcing adaptive coping mechanisms, and this includes mobilizing social support among the patient's family and community.

Clark (1988) offers some recommendations for how law enforcement and emergency services personnel can best deal with crime victims on scene; I have found that these also readily apply to the work of mental health professionals who deal with crime victims on scene, in emergency rooms, at police stations, and at sites of workplace violence (Miller, 1995, 1997, 1998b).

The responder's first concern is to see that serious injuries are treated. The approach to patients
during this stage can have a significant impact on their subsequent level of cooperation and overall psychological recovery. Clark (1988) offers several commonsense guidelines for emergency responders that differ little from methods of crisis intervention used by mental health professionals for patients in acute distress.

First, introduce yourself to the patient and bystanders. Even if you are in uniform, have a picture ID tag, or “look like a doctor,” the victim may be too distraught to understand who you are, and may even mistake you for the criminal. Avoid accusatory statements such as “What were you doing out alone at this time of night?” or “Why did you let him into the house?” and also hollow platitudes such as “It’s okay” or “Everything will be all right.” More helpful are concrete supportive statements such as “We’re here to treat your injuries” or “We’re going to take you to a safe hospital.”

Although less problematic among mental health professionals than among law enforcement personnel, it is important to avoid statements or actions that indicate a patient should “Stop crying and act like an adult.” People who have been victimized do not act the way they normally do and many crime victims revert to child-like behavior after the incident. Simple, nonjudgmental statements such as “I can understand why you are upset” or “What can I do to help?” can greatly ease the patient’s distress.

Listen to the victim if he or she wants to talk. It is the mental health clinician’s essential role to listen; emergency medical or law enforcement personnel may not consider empathic listening to be part of their job description. Yet even the most hard-boiled detective or trauma medic should understand that a sympathetic, nonjudgmental responder can do much to restore the crime victim’s trust and confidence and thereby facilitate all aspects of the case. Do not press the victim for more details than you need to know in order to perform your treatment. Victims will be asked to tell their stories again and again, especially if they become involved in the criminal justice system. It is important, however, to allow victims the opportunity to express their emotions if they feel the need to do so (Clark, 1988).

**Psychotherapy**

Once the immediate crisis has passed, the patient is confronted with the process of working through the trauma of victimization and trying to get on with life. The following are examples of therapeutic guidelines and recommendations for two types of crime victim trauma: rape and sexual assault and family bereavement by homicide.

**Exposure therapy and desensitization.** Falsetti and Resnick (1995) describe an application of prolonged imaginal exposure therapy to the treatment of violent crime victims. Although not without its critics, this approach has proven effective in treating PTSD in Vietnam veterans, and more recently it has been applied to rape victims with PTSD (Foa, Rothman, Riggs, & Murdoch, 1991). One of the primary goals of exposure therapy is to confront the feared stimuli in one’s imagination so that fear and anxiety decrease. Patients are asked to confront fear cues that are not dangerous in themselves but that may have been paired with danger at the time of the traumatic event. In vivo exposure to fear cues is used to extinguish the fear associated with these stimuli. This involves exposure to objects or situations in real life, such as having a woman who was raped in a parking garage sit in such a garage with her therapist in order to learn that it was not the parking garage itself that was dangerous but, specifically and restrictively, her assailant.

Despite the success of prolonged exposure treatment, it has been recommended that this modality be used with caution because of the potential for severe adverse complications, including precipitation of panic disorder, exacerbation of depression, relapse of substance abuse, and hypersensitization and retraumatization (Pitman et al., 1991). In addition, flooding used alone has received criticism because it does not address faulty cognitions and fails to enhance the development of coping skills.

Foa, Hearst-Ikeda, and Perry (1995) have developed a clinical intervention brief prevention program for treating complicated PTSD reactions in victims of sexual and nonsexual assault. The elements of this program can be readily adapted to most forms of crime victimization and to other types of noncriminal trauma (Miller, 1998a). Foa et al.’s (1995) program consists of four weekly meetings, two hours each, of cognitive-behavioral therapy. The program consists of techniques that Foa et al. (1991) have found effective for alleviating chronic PTSD in assault victims. These include (a) education about the common reactions to assault; (b) breathing and relaxation training; (c) reliving the assault by imaginal
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exposure; (d) confronting feared, but safe situations (in vivo exposure); and (e) cognitive restructuring.

Meeting 1 is devoted to information-gathering, education, normalization of the trauma experience, clarification of cognitive distortions, and identification of safe people and situations. In meeting 2, relaxation and other behavioral medicine techniques are taught in order to counteract the hyperarousal associated with feared trauma-related stimuli. Meeting 3 focuses on cognitive restructuring of maladaptive cognitive distortions related to the trauma and its aftereffects, including global unpredictability and uncontrollability, negative self-views, fears and expectations for the future, and extreme beliefs about the world and its inhabitants. Meeting 4 concentrates on consolidating, reinforcing, and extending the skills learned in the program, and arranging for any necessary follow-ups.

Foa et al. (1995) studied the efficacy of this brief prevention program with 10 females who were recent victims of sexual and nonsexual assault. Two months postassault, victims who had undergone the cognitive-behavioral prevention program had significantly less severe PTSD symptoms than victims in the assessment control condition. Five and a half months postassault, victims in the brief prevention group were significantly less depressed than victims in the control group and had significantly less severe reexperiencing symptoms. The prevention program was also effective in reducing depression.

Foa and colleagues (Foa et al., 1995; Foa & Kozak, 1986; Foa & Riggs, 1993) hypothesize that the behavioral prevention program enables victims to repeatedly relive the traumatic memories, thus activating the trauma structure and its emotional component and leading to desensitization and habituation. This in turn helps modify the patient's perception of herself or himself as weak, helpless, and inadequate and creates a sense of competence, control, and self-efficacy.

An extension of this approach has been studied by Echeburua, de Corral, Zubizarreta, and Sarasua (1997), who compared self-exposure and cognitive restructuring with progressive relaxation training in the treatment of adult rape victims and adult victims of childhood sexual abuse. In contrast to Foa and colleagues (Foa et al., 1991; Foa et al., 1995), the exposure technique used in Echeburua et al.'s (1997) program addresses the stimuli the patients tend to avoid and is applied to current intrusive thoughts more than to traumatic memories, per se. The cognitive restructuring technique focuses on (a) normalizing the stress reaction to sexual assault; (b) modifying catastrophic and dysfunctional thoughts, feelings, and beliefs about the assault; and (c) putting the experience in a positive perspective by emphasizing adaptive coping skills and hope for the future.

Results have shown that the combination of self-exposure and cognitive restructuring modalities is far superior to progressive relaxation in reducing traumatic stress symptoms in these sexual assault survivors, both immediately and at a 12-month follow-up. In fact, the authors report a startling 100% success rate at 12 months for their cognitive-behavioral treatment program (Echeburua et al., 1997).

With appropriate modifications, these kinds of cognitive-behavioral treatment approaches can be used for other types of crime victims, as well as victims of disasters and automobile accidents. The key elements in such therapeutic programs appear to be (a) the instillation of hope, control, and empowerment by the progressive mastery of physiological arousal and practical coping skills; (b) the reconceptualizing of the self as an active, competent agent in directing one's own life; and (c) the development of a posttrauma worldview that combines a more realistic perspective on human nature with the ability to sustain positive human relationships and move on with one's life (Miller, 1998a).

Psychotherapy of bereavement by homicide. Few family victimizations are as ferociously tragic as the death of a loved one by homicide (Schlosser, 1997). Rage, horror, and despair all comingle as the survivors struggle for understanding and a sense of justice—indeed, for a reason to go on, to “keep fighting,” as several have put it, as living itself becomes a battle. While a number of authors have tangentially touched upon the therapeutic issues of family member homicide survivors, this topic has been most extensively addressed by Rynearson (1988, 1994, 1996) and Rynearson and McCrery (1993), and this section is based largely on these works, along with the author's own clinical observations.

Unlike a death that is preceded by a serious prolonged illness, bereavement by sudden and unanticipated death is frequently more painful and prolonged because of the absence of anticipatory bereavement. In the case of murder, the dying is both violent and transgressive, a brutal, purpose-
ful assault forced on an unwilling victim. It is often a widely publicized event, and the bereaved may be forced to cope with the demanding processes of investigation, apprehension, trial, sentencing, and media intrusion that necessarily divert attention and energy from the primary tasks of mourning and recovery. Posttraumatic stress reactions to a family member's murder can take several forms (Rynearson, 1994, 1996), affecting emotions, cognition, and behavior.

Emotionally, in addition to the feelings of sadness, anxiety, and guilt commonly associated with any bereavement, in the case of homicidal bereavement, a pervasive fear begins in the survivors with their awareness of the murder, a fear that can last for several years. A deep and justifiable anger toward the murderer alternately smolders and flares as the trial meanders along. Even after sentencing, this anger might diminish over several years, but it never disappears entirely.

Cognitively, the presence of intrusive, repetitive images of the homicide may appear as nightmares or waking flashbacks that focus on the presumed terror and helplessness of the victim during the last minutes of his or her life. The survivor's memory and concentration may be impaired, affecting work and social functioning. Survivors may have dreams and conscious fantasies of avenging the victim by murdering the murderer. Grotesque death imagery may be intense and frightening in individuals who have lost a relative through homicide, though they may not have witnessed the murder directly or viewed the body. Because of their psychological attachment, the survivors are left to work through an internalized fantasy of grotesque dying. I've observed that, for some survivors, body identification is the worst part of the whole ordeal of homicidal bereavement. For others, the actual sight of the deceased provides a strange sort of reassuring confirmation that the murder victim's death agonies may have actually fallen short of the survivor's imagined horrors; even if not, the physical presence of the body means that the victim's suffering is finally over.

Behaviorally, up to a year or more following the homicide, there is a heightened anticipation and protective avoidance of violence, including hypervigilance and startle reactions. The individual's usual range of territorial and affiliative behaviors becomes constricted as the home is turned into a protective fortress, strangers are avoided, and unfamiliar surroundings are circumvented. There is a compulsive need for surviving family members to be close at hand or reachable at a moment's notice. Behaviors directed toward retribution begin with cooperative efforts with police investigations and apprehension of the murderer. This may mushroom into obsessive preoccupation with judicial actions that promise justice and punishment. Individuals who are bereaved through homicide commonly identify with victims of other crimes.

Rynearson (1988, 1996) offers some recommendations for treatment of families of homicidal bereavement, especially involving a murdered child. They are presented here with some of my own clinical observations.

In the beginning phases of treatment, beware of pushing the cathartic narrative too quickly. Many bereaved patients adopt either an unnatural flippancy or a hyperrational attitude in the early aftermath of homicidal bereavement, which observers may mistake for unconcern or callousness. This anomalous emotional tone typically represents a massive defense mechanism and, especially in the early stages, some patients cope better using avoidance as a supportive crutch, which should provisionally be respected by the therapist. There is nothing to be gained from dramatic displays of emotional agony: this will happen soon enough. The therapist should take a cue from the patient's history (where this can be elicited) of dealing with traumatic events in the past. The judicious use of antianxiety, antidepressant, and sleep mediation, as well as relaxation training and cognitive-behavioral stress management techniques may help quell vicious cycles of arousal and withdrawal. Learning to modulate one's own arousal level is often the first step toward regaining a sufficiently secure sense of control to allow expressive psychotherapy to take place.

At some point, the therapeutic narrative begins to flow. Psychotherapy of the homicidally bereaved patient combines many of the features of individual PTSD therapy and family therapy modalities. Before being able to discuss the traumatic death, the patient and the therapist must first establish a basic alliance that promises sufficient support and security to accommodate and assimilate what has happened. The security rests upon the nonverbal capacity to modulate intense fear and divert one's mind from horrifying imagery. Inquiry about the patient's private perception of death is another early task of assessment. Nihilism and despair are common early responses, and
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helping the patient recover or develop sustaining spiritual or philosophical beliefs or actions can buffer the disintegratory effects of the homicide. Therapeutic measures may involve exploring the patient's concept of death and meaning in general and encouraging a return to church, a retreat-like visit to the woods or ocean, or renewed commitment and caring for others. Pictures of the deceased can also serve as comforting images. In reviewing family picture albums together, the therapist and patient can summon nurturant, positive imagery that may counterbalance the grotesque imagery of the homicide. Similar activities include writing about the deceased or creating a scrapbook, as long as these do not become an unhealthy, obsessive preoccupation (Rynearson, 1996).

Once the psychological coping mechanisms of self-calming and distancing from the homicide event are strengthened, therapy can begin to confront the traumatic imagery more directly. Less verbally expressive patients may be asked to draw their perception of the scene of death to provide a nonverbal expression of reenactment that can be directly viewed and shared by the therapist. (This type of drawing exercise is very effective with traumatized children and adolescents, not just with traumatic bereavement but more generally in trauma work; see James, 1989.) Efforts by patients to place themselves within the reenactment draw allows a beginning of abstract distancing instead of mute avoidance. In these exercises, patients often portray themselves defending, holding, or rescuing the deceased.

At this point, it is hoped that the patient has gained sufficient autonomy from the trauma of homicide to begin addressing less immediate issues, including self-esteem enhancement, dealing with survivor guilt, delineation of previous vulnerabilities, and any complexities or ambivalences in his or her relationship with the deceased.

Special problems arise when a child is killed by another family member, confronting the entire family with the dilemmas of identification, divided loyalties, belief, and trust. Intrafamily killing accounts for 25% of homicides and often occurs in families with a long history of dramatic dysfunction. In these cases, not only will all the family members identify with the victim, but they are identified with the murderer as well. These families need specialized, skilled intervention, and even with this care the prognosis for a positive family outcome remains guarded—as it probably was before the homicide.

When a child has disappeared, the acceptance of homicidal death cannot begin until the body is found or the family ceases searching—and many families never stop. When the murder remains unsolved, as it does in 28% of homicides, the bereaved are left with an internalized traumatic dying that remains unbuffered by solution, punishment, retribution, or redemption (Rynearson, 1996).

When the family is ready, the therapist should encourage participation in appropriate support groups, such as Compassionate Friends, Parents of Murdered Children, and similar local and national groups. When our traumatically bereaved patients tell us that "you can't possibly believe what we're going through," they are right. We cannot, unless we've lived through it ourselves. That does not rule out our being therapeutically effective, just as therapists who successfully treat terminal illness patients, children with learning disabilities, brain-injured patients, or schizophrenics need not suffer these syndromes themselves. But a group of peers is a powerful therapeutic adjunct for almost any kind of traumatic disability syndrome (Miller, 1992, 1993); often, in fact, meaningful psychotherapy cannot be wholly successful without such in-group comradeship. In the case of bereavement by murder, the support group members who have survived the horror share an immediate resonance and empathy with the specific aftereffects of homicide and embody the hopeful promise of recovery for new members. The group can also guide new members through the uncharted experiences of public scrutiny with press and television and the investigative and judicial ordeal to come.

Psychotherapy of child survivors of family homicide. Almost inevitably, the family members a murder victim leaves behind will include children and adolescents. Recently, a few innovative attempts have been to develop treatment modalities for these young survivors. Temple (1997) describes a treatment approach with siblings of inner-city homicide victims. He notes that, in addition to the usual traumatic bereavement issues, siblings of murder victims often struggle with urges and social pressures toward retaliation, thereby putting themselves and others at increased risk for violent death. Older siblings may be plagued by guilt for "not looking out for" the younger brother or sister, and this may further fuel the impulse toward self-justifying revenge.
The treatment goals of Temple's (1997) program, called contextual therapy, include (a) rapid restoration of family functioning following the homicide; (b) prevention of retaliatory violence by family members of the deceased; and (c) encouragement of family members to develop future plans based on honoring the memory of the murdered loved one. These goals are achieved by quickly and effectively connecting the involved families to a wide range of practical and supportive services and by encouraging them to support one another. In addition, psychotherapy with siblings focuses on deriving some meaning or lesson from the deceased's life and death and honoring the deceased's memory by both symbolic artifacts (e.g., a scrapbook or photo album) and behaviors (e.g., establishing a productive direction in life or becoming active in antiviolence programs).

In addition, the contextual therapy program concretizes the therapeutic gains by awarding therapeutic "Certificates of Healing" to siblings who have shown courage and dedication in confronting their feelings and developing ways to positively honor the memories of their murdered family member. The contextual therapy program reportedly continues to enjoy great success in the inner-city neighborhoods of Kansas City, Missouri, where it originated (Temple, 1997). Long-range follow-up studies of this program are eagerly anticipated.

Parson (1997) describes a program of posttraumatic child therapy for working with inner-city children exposed to catastrophic community violence, including murder of a parent. The therapy consists of several phases. In phase 1, the pretherapy phase, modeling, role-playing, and psychoeducational techniques are used to (a) give the child an age-appropriate cognitive grasp of the reasons for the therapy; (b) explore the child's meaning associated with coming to therapy; (c) understand the child's "personal theory" for his or her traumatic symptomatology; (d) explore the child's meaning system for the traumatic loss; and (e) understand the child's expectation of helpful or harmful results of therapy.

Phase 2 is termed stabilization of biopsychic response and includes (a) establishment of a therapeutic relationship with an adult who exhibits confidence, calming reassurance, and a helpful attitude toward the child; (b) arrest or reversal of biopsychic decline; (c) initiation of control over inner turmoil and chaos; (d) beginning to get reasonable control over the external environment; (e) initial exploration of specific elements of the traumatic experience; (f) continued development of trust; and (g) the foundation for the next phase of treatment.

Returning to the psychogeographic scene forms the basis of phase 3 which involves (a) deconditioning of negative affect through the use of in vivo systematic desensitization; and (b) the cognitive-behavioral working-through of trauma through the use of play therapy and other techniques.

Phase 4 is the completion—moving toward growth and integration phase. This mainly involves using the transferential and relational aspects of individual trauma psychotherapy to help the child restructure his or her self-view and worldview, to develop what is termed a new posttrauma meaning system. In this respect, the goals of Parson's (1997) system come close to those of trauma therapy for adults. The advantage of Parson's (1997) and Temple's (1997) approaches with children is that they use child-appropriate therapeutic techniques to establish competence and control, and thereby pave the way for the young patient's eventual ability to profit from reconstructive and integrative techniques of trauma therapy (see also James, 1989; Johnson, 1989).

In addition, note that many adult trauma patients may present in such a regressed, decompensated state that these preliminary techniques of arousal regulation and trust restoration are appropriate in the early stages of their treatment as well (Everstine & Everstine, 1993; Matsakis, 1994; McCann & Pearlman, 1990; Miller, 1994, 1998a).

In general, therapists need to remind themselves of the limited therapeutic goals in most cases of homicidal bereavement: do not expect families to totally "work through" the trauma of a murdered loved one; do not tell them they will "get over it." They will not. The bereaved will always maintain an attachment to the dead family member, especially to a child, and it would be a mistaken therapeutic objective to insist on complete decathexis. Instead, it is hoped that the bereaved will learn to maintain involvement with others, while always retaining an internalized relationship with the slain child's image. The therapist's job is, first, to keep the family members from destroying themselves and each other, and second, to restore meaning and purpose in their lives that allows them to remain productive, functioning members of their community. The crucial first step is often to get the family members to
believe in one simple fact: "You can live through this." In the best cases, family members may "grow" from such a horrendous experience, but such cases are the blessed exceptions, and many families do well just to survive.

Summary and Conclusions

To be truly effective and comprehensive, psychotherapy of crime victims must incorporate some or all of the following modalities as necessary:

1. Crisis intervention at the scene or soon afterward (e.g., at the hospital or police station).
2. Provision of, or direction to, appropriate legal and social service-based victim support systems.
3. Desensitization and low-arousal applications of behavioral medicine modalities for adequate control of posttraumatic symptomatology.
5. Working through of the trauma and integration into the survivor’s life story.
6. Practical guidance and emotional support through the inevitable legal ordeals associated with the criminal case.

In conclusion, working with bereaved families of homicide victims or individual survivors of criminal assault often confronts therapists with the darkest aspects of human nature. Therapists who can focus their healing efforts productively, and avoid becoming traumatized and emotionally exhausted themselves (Miller, 1998b) represent vital allies of the forces of law, justice, health, and civilization.

References


