VICTIMS OF CRIME - VICTIMS OF STRESS

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by

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This presentation is based upon personal theory and a victim's knowledge and understanding of traumatic stressors and their deadly side effects. In fourteen years as a volunteer and victim advocate, during which I have worked with hundreds of violent crime victims, I have yet to meet a victim/survivor that did not exhibit several classic symptoms of Post Traumatic Stress Disorder.

The above paragraph is the basis for my hypothesis that Every Victim of Violent Crime Suffers from Post Traumatic Stress Disorder. Victims of this disorder are therefore predisposed to compromised immune systems and the unlimited range of illnesses and diseases associated with immune system deficiencies.

Whether the differential diagnosis of PTSD is Primary or Secondary, it is doubtful that victims can achieve any lasting benefit from therapy (2-b). " . . . The disorder is apparently more severe and longer lasting when the stressor is of human design. (2-c)

Professional treatment remains an important and valuable tool that must always be available to victims and survivors of violent crime. When properly administered by trained and experienced professionals, treatment may restore a modified level of toleration of the disorder, but never a cure. Improper treatment on the other hand, by well meaning but untrained therapists, yields a counterproductive situation that few victims allow to continue.

Until more is known about victimization, professional therapists must continue treatment based upon protocols developed from generalizations derived from studies of very few victims and survivors. A victim researcher said on launching one of his latest studies and I paraphrase; what we know about victims and effective treatment protocol comes from generalized reports from treatment of a few victims in a clinical setting. Presently there have been no non-clinical projects to support these inferences.

Perhaps nearly as important, many of these professionals lack appropriate education and experience to treat victims and survivors but without more knowledge of victims and survivors, this training will continue to be incomplete.

We must work to develop projects that will allow us to study and learn more about the nature of victimization and its destructive devastation on victims and survivors. Of all the tasks that lie before the professional community, studying victims and survivors will undoubtedly be the most difficult challenge of all. From the point of initial notification to a time weeks later, grief, PTSD, and proprietary restraints, make it extremely difficult or impossible for researchers to make meaningful and productive contact toward a goal of learning more.

Most who have studied PTSD and even the DSM-IV (3-b) make use of the term "With delayed onset." Government agencies and the medical community also widely accept this term. I feel that this term is not terribly accurate. Sudden trauma "beyond the range of normal human experience" is the onset of PTSD. Additive and cumulative stressors further exacerbate the condition. To this we must also add grief that is prevalent in crimes of violence. It is my theory that Grief and Post Traumatic Stress Disorder run concurrently. PTSD impedes the progress of grief and grief in turn masks the symptoms of PTSD for a significant time. I believe this interaction is responsible for the term "With Delayed Onset (3-a)." In other words the symptoms are masked, giving the appearance of being delayed but, the disorder is already present, active, and destructive.

When victims and survivors present themselves for professional treatment many therapists, frustratingly attempt to fit victims and survivors into a Standard Freudian Model. This may be a mechanism to help the therapist further an understanding of victimization. However, these diagnostic attempts yield only bitter frustration and resistance from victims and survivors. Much valuable and precious time is lost as the therapist seemingly works at great length to develop a differential diagnosis. These age-old standards work with patients whose disorder is a natural occurrence however, applied to victims and survivors these tactics will bring therapy to a sudden and permanent end. In the end the victim and survivor will suffer most. Symonds calls this "the second injury."(APA, 1980, p 237)

Add to this the extremely high fees charged by therapists and one quickly realizes that treatment is out of reach for most victims, survivors, and families. Victims Compensation Programs in most states and the federal governmental agencies of the United States provide limited treatment for victims and survivors. However, this therapy is seldom allowed beyond one year from the onset of the case and this disregards the delayed onset of the disorder as specified in DSM-IV.

We frequently advise our victim/clients, especially those with a standing of several years that as victims and survivors, we move from one crisis to another, one disaster to another. Simple, nearly meaningless, everyday stressors to most people, are cumulative and additive stressors to victims and survivors. These common stresses when added to traumatic victim stressors raise the nature of the disorder to astonishingly destructive levels. Taking their cumulative nature into consideration, normal everyday stressors add significantly to existing severe trauma stressors and in time, without appropriate treatment, can yield a compromised human immune system. These sudden, devastating traumatic stressors coupled with nearly traumatic daily stressors present illnesses that even time is unable to mitigate.

Medical science has long known that high levels of stress, left untreated can cause damage to or destruction of the human immune system (1). From Stress, the Immune System, and Psychiatry (5), "There is increasing evidence of the interactions between psychological stress and psychiatric illness on the one hand and response to the immune system on the other. The last few decades have also demonstrated that, if stress interferes with the smooth running of the immune system, changes occur which enhance disease susceptibility and adaptive behavior during the course of disease. There is therefore a real need for the objective assessment of the importance of psychoneuroimmunology which provides pointers for the clinical application of this emerging discipline."

Researchers at Yale University have found physical changes in the hippocampus of victims of depression and combat veterans. It does not require much logic to conclude that similar changes would also be found in victims of violent crime.

I was amazed to find from my preliminary search for data and documentation, that what is written in these pages is nothing new to the medical community. However, from the viewpoint of a victim of Post Traumatic Stress Disorder, the conclusions from years of study, thought, and experience discussed in this paper, while extremely logical are indeed new.

"Professionals interested in treating or studying PTSD threaten to disturb a fragile equilibrium. Fear of effect over-load makes the survivor wary . . . (Lindy, 1986, p. 154) " "Because victims may go through a denial phase in response to a stressful event (Horowitz, 1976), clinical access may be difficult to gain." (2-a) [Author's Note: Every victim/survivor must go through the denial stage of the grieving process.]

"Uncontrolled stress has destructive physical and psychological consequences." (2-b)
"Exposed to a 'psychologically traumatic event outside the range of usual human experience . . . most people will develop PTSD (APA, 1980, p.236) (2-d)

That stress has reached unprecedented levels of devastation and seriously destructive capabilities is no surprise either. The cost of overlooking or failing to consider stress disorders exceeds 150 billion dollars annually, in the United States alone. This is appalling. Stress disorders are an extremely burdensome and expensive element of modern society but the costs in victims and survivors are even greater.

"Stress is a major contributing factor either directly or indirectly, to coronary artery disease, cancer, respiratory disorders, accidental injuries, cirrhosis of the liver and suicide; the six leading causes of death in the United States. Stress aggravates other conditions such as multiple sclerosis, diabetes, herpes, mental illness, alcoholism, drug abuse, and family discord and violence." (4)

Each of us responds differently to traumatic stressors, even those within the same family. The severity of stress disorders on victims is dependent on a variety of conditions. I classify these as the 'Ambient Environment.' These ambient environmental conditions include, but are not limited to, financial health, emotional health, strength of relationships, emotional and coping skills development, and many other controlling influences on our everyday lives. In time a quantifying test might be developed to measure predictable responses to traumatic stressors. This quantification would only be a guide, not a limiting constraint on treatment or services for victims and survivors.

The importance of the quotation from Stress, the Immune System and Psychiatry is a basis for a typical case that I wish to present with the understanding that it is but one of hundreds that I could have chosen. However, none are more familiar than that of my son Eric.

At the time of my thirteen-year-old son Patrick's murder in 1983, Eric was 10 years old. At the time I was not aware of the fact but after one or two media interviews, it was clear that Eric was in deep denial. Once Pat's case was no longer newsworthy, Eric began acting out and exhibiting a transference of many of

Patrick's mannerisms; some of which continue to this day (he is now 26). " . . . changes occur which enhance disease susceptibility and adaptive behavior . . . " (5)

While we were trying to get our family life back on track, grief and stress were weaving their devastating course Eric, in the third grade, returned to school. Soon however, the earliest symptoms, typical of young siblings began surfacing. Two weeks after our family tragedy, he began to misbehave both at home and at school. Within a month of his return he started experiencing a variety of illnesses such as headaches, stomachaches (3-b). Nothing serious, but enough to keep him home from school. At first this was an occasional event but it quickly grew to a regular happening. Visits to our family doctor while inconclusive suggested that these ailments were not physical. This behavior continued for many months. By the time he entered the fifth grade it was more convenient to allow him to come home from school rather than encourage his attendance. From his return to school after Patrick's murder, the school system failed to recognize his behavior much less understand it . . . after he expressed a desire to end his life they simply found it expedient to give up on him.

Because of his threatened suicide, we enrolled our family in a trauma study project at a local university. By attempting to force a differential diagnosis and totally misunderstanding the criticality of the situation and the nature of the disorder most of our family became disillusioned and angry with the process. By the third session we reached a decision that further attendance was no longer a valid option.

In reality, Eric's learning ended with the trauma of his brother's murder and by the middle of his seventh grade we were advised to withdraw him from the school system and enroll him in the local vocational technical school. Reluctantly, we followed their advice. By the end of the school year though, Eric's attendance in school ended and so did his education.

The resultant failure of the school system, counselors, and teachers left a very bitter and frustrated youth, little better than functionally illiterate.

This was a classic case of professionals that were unprepared and uneducated in working with victims and survivors of violent crime. Today, more than a decade after this secondary tragedy, schools react much differently. When similar tragedies happen now, teams of counselors are assigned to the school and students affected by the incident, including victims and survivors. These specialists remain

on station as long as needed and as necessary refer students to outside therapy. Considering present day procedures, I have concluded that, within two to three weeks Eric would have been referred to long-term therapy and that treatment would have continued for a several years.

Another case that needs to be included is another personal citation that is terribly important. In presenting this paper I have developed the relationship between Post Traumatic Stress Disorder and damage or destruction to the human immune system. As a victim/survivor of more than one traumatic incident, I was not exercising self-control over my ambient environment, also known as my personal lifestyle.

Suffering from painful angina, my cardiologist insisted that I always carry a supply of nitroglycerine with me. Then during a later follow-up appointment he dropped a bomb on me. Essentially he told me that piece by piece and day by day, I was committing suicide. He advised that he did not expect me to live longer than three to six months without drastic changes. These changes needed to include a proper and nutritional diet, loose nearly 100 pounds, start a program of regular exercise, and I needed to quit smoking. My drive home that day was an exercise in terror.

This paper is not the place to include all that the doctor was planning for me and my new lifestyle but I none of it was acceptable. Since I was a Lifetime member of Weight Watchers from 1977 seemed logical that this was where I needed to begin. A few days later I returned to Weight Watchers Program and as I presented my lifetime booklet and signed in I took the cigarettes from my shirt pocket and dropped them in the waste paper basket. My efforts to quit smoking were immediately successful, and I never experienced the typical cravings for the deadly sticks. Eight months later, I reached my goal weight of 150 pounds; after my initial weight loss of 97 pounds I trimmed my weight further to 136 pounds, a weight that I have maintained for over two years. As an example of the change I went from a HIGH Fat diet to the point that I now have a difficult time getting sufficient daily fat for proper body function.

Now the tie in. As the pounds melted away, I began to feel better about myself than I had since 1983 and my emotional health, while still suffering from PTSD, continues to improve. Considering the differences and the consequences I understand now that as a victim of PTSD, I am predisposed to a compromised immune system and that I was helping the illness progress, nearly to the point of death. More importantly though, by making the changes I have, I am working just

as hard to prevent further damage or destruction. Much of the damage I had done to my body and my person has now for the most part been reversed.

This paper does not insinuate that every victim of violent crime will suffer from a compromised immune system or the devastating, deadly diseases associated the deficiency. However, it does not suggest that every person suffering from a damaged immune system or the associated deadly illnesses are necessarily victims either.

The references cited in this paper and its companion document Stress Disorders - a New Classification, and my Victim Advocate experience suggests that there has been significant improvement in the treatment of victims and survivors of violent crime. However, much more is needed.

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