

Literature Review:

Community-Based Response to Criminal Mass Victimization

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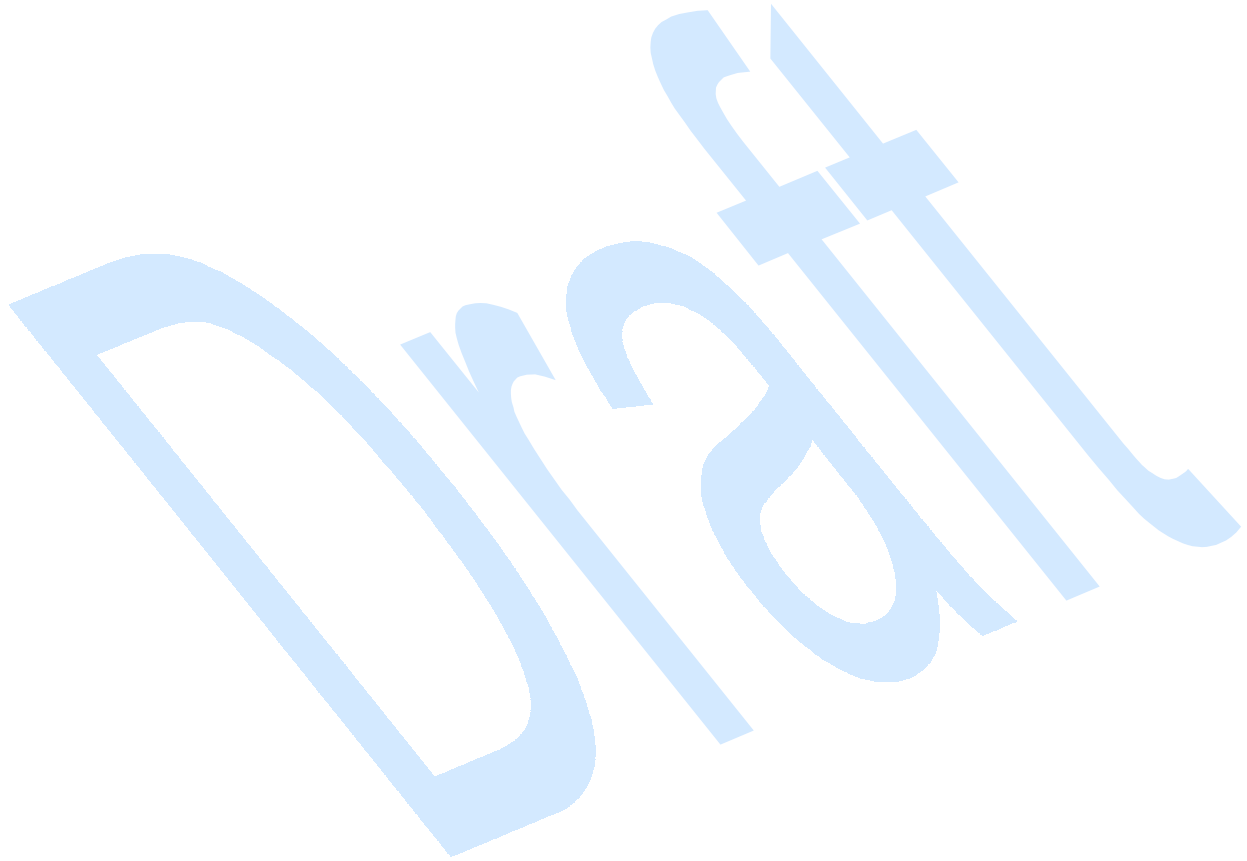
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INTRODUCTION

The following report is a review of the professional literature related to man-made disasters involving a criminal act(s) which result in mass victimization. The focus of this review was to examine the possible impacts an act criminal mass victimization (CMV) has or might have on a community, what is involved in a community's ability to cope with it and what a community can do to prepare themselves to most effectively handle such an act.

After reviewing the existing literature, it was determined to present the information in terms of the nature of, impact of, response to and preparation for criminal mass victimization.

NATURE OF DISASTER AND CRIMINAL MASS VICTIMIZATION

Criminal mass victimization is best understood in the context of all the disasters that can befall human beings. In fact, the impact of these extraordinary events is even clearer when viewed as a special type of disaster experience.

There have been several attempts to develop typologies of disasters and highlight the differences between them. Taylor (1989) described disasters as either natural, industrial or human while Berren et al (1989) distinguished them as either natural or human and further described two types of human induced disaster, "acts of omission" and "acts of commission." Ofman et al (1985) reviewed the differences between the natural and manmade disasters highlighting the difficult impact of mass criminal acts. He noted that in natural disaster, there is an identifiable low point when the worst is over. In manmade disasters, there is continuing uncertainty about the beginning, end and the continuing effects the incident might have. In addition, the motive, logic and "psychological makeup of the perpetrator must be faced." Weisaeth (1994) also emphasized the impact of manmade disasters such as criminal mass victimization. He observed that natural disasters have been part of human life for millions of years and suggested that there may be an increased ability to adapt to these events. He also observed, "Nature can do harm but nature has no evil intent"(p. 75) and "Nature does

not threaten man's self respect even if it kills him" (p. 76). Lastly Weisaeth suggested that unfamiliarity, unpredictability, uncontrollability and culpability are all characteristics of difficult disasters, especially criminal mass victimization.

There have been a number of attempts to describe the characteristics of disasters as way of predicting their likely impact. These efforts assume that the more difficult the incident, the more likely an individual or community may be impacted. Dynes (1970) has argued that disasters can best be understood through the following dimensions; frequency, predictability, controllability, cause, speed of onset, length of possible warning, duration, scope of impact and destructive potential. Hartsough & Myers (1985) suggested that the following characteristics are associated with an increase in impact among survivors. They include:

- Lack of warning**
- Abrupt contrast of scene**
- Type of disaster**
- Nature of destructive agents**
- Degree of uncertainty and duration of the threat**
- Time of occurrence**
- Scope of the event**
- Personal loss or injury**
- Traumatic stimuli –sights sounds, smells, etc.**
- Human error**
- Lack of opportunity for effective action**

In their comprehensive review of children and disaster, Vogel & Vernberg (1993) reviewed the characteristics of disasters that have been shown to be related to difficult psychological consequences among the young.

- **Child perceives a strong life threat**
- **Child is seriously injured**
- **A family member is injured or dies**

- **A close friend or companion dies**
- **Major property damage increases the likelihood of short-term distress**

Recently, there has been an increased interest in understanding disasters as community events. Young (1989) created a list of characteristics of disasters that may be predictors of great community impact. These include:

- # **Causes death or realistic threat of death to all members of the community**
- # **Occurs within communities in which people are strongly affiliated with each other**
- # **Is witnessed by community members**
- # **Involves individuals with special significance to the community affected**
- # **Causes the community to be exposed to extraordinary carnage or misery**
- # **Calls for numerous rescue workers or helpers**
- # **Attracts a great deal of media attention**

Even a cursory examination of the various ways of characterizing disasters makes it clear that criminal mass victimizations are among the worsts of human experiences.

IMPACT OF CRIMINAL MASS VICTIMIZATION

The high levels of community disruption, violence, physical and property damage seen in criminal mass victimization would lead many to conclude that most, if not all of those impacted by these events experience great psychological distress. However, years of research have provided a complicated picture of the impact making the response to criminal mass victimization a difficult task.

A number of researchers (Hartsough & Myers, 1985, Cohen & Ahearn, 1980 and Hoff, 1984) have suggested that the following factors put survivors of disaster at risk for the development of difficult psychological consequences. These include:

- **Age and Developmental Phase** -- skill level and life experience, i.e., very young and old.

- **Health** – poor health and recent ill health may be risk factors as a result of physical limitations, cumulative stress, or inability to obtain treatment of medication
- **Disability** – Impairment of mobility, sight, hearing or speech
- **Preexisting Stresses** – recent job changes, financial concerns, relocation and stressors, etc.
- **Previous traumatic life events** – successful outcomes may assist with coping skills while poor coping may increase vulnerability
- **Strength of support system** - absence of loss of social and psychological support system
- **Coping skills** – poor or maladaptive coping skills
- **Expectations of self and others** – family members needing care, small children or high self-expectations
- **Status of family members** – separation, unsure of status
- **Ethnic and cultural mileau** – language barrier and cultural differences
- **Perception and interpretation of the event** – perception of event changes impact

Milgram et al (1995) reviewed the literature in disaster consequences and noted the following high risk groups:

- **Elderly** - may be overlooked and less likely to receive assistance. They may be unable to rely on surviving kin for assistance.
- **Children** – their helplessness may expose them to ineffective assistance or predators
- **Rural population** – lives far away from facilities and when they do, receive services, it is often very late
- **Economically disadvantaged** -- may be less knowledgeable about gaining support and are less likely to get it.
- **Without Relatives** – more likely to become depressed and less able to mobilize support
- **Prior Distress** -- those who have received less support in prior disasters tend to expect less in subsequent disasters

Numerous studies and reviews have attempted to understand the impact of disaster. For example, a study of those seeking compensation for psychological damage after the Lockerbie air disaster (Brooks and McKinlay, 1992) found high levels of psychological symptoms in its sample. Symptoms of Posttraumatic Stress Disorder (PTSD) were often accompanied by depression, and other anxiety

disorders. There was no relationship between age, gender or marital status and difficulties but those experiencing the death or injury of family or friends reported more problems.

In a National Center for Post-Traumatic Stress Disorder publication, Solomon and Green (1992) review the mental health effects of disaster. They note that while some studies show “little or no negative effect” (p. 1), most research now suggests that disasters can impact mental health status. In those studies which do show an impact, a large number of problems have been identified including PTSD-like symptoms, depression, alcohol abuse, anxiety and somatization, physical illness, domestic violence and general difficulties such as distress, performance and physiological reactivity. The authors also looked at the question of long-term mental health effects on survivors of disasters and concluded that the consequences for natural disasters are reduced in about 12-16 months but may persist for many years in human-caused disasters.

It may also be useful to examine the relationship between being the victim of a crime and later emotional difficulties in understanding the impact of mass victimization. Studies indicate that between 24% and 65% of women exposed to a traumatic victimization report symptoms of PTSD (Boudreaux et al, 1998). A more recent study examined the relationship between exposure to criminal victimization and other mental health issues. And noted increased levels of depression, agoraphobia, obsessive-compulsive disorder, social phobia and simple phobia in a group of women (Boudreaux et al, 1998).

Vogel & Vernberg (1993) reviewed the impact of disasters on children and noted that various studies indicate that between 27% and 50% of children will develop PTSD after exposure to disaster. The level of distress appears to be associated with the degree of life threat to the child, level of symptoms in the child’s parents, severe damage to property, those that evacuate and do not return to their homes and injury to self or others. Children who develop mild to moderate symptoms are most likely to have fears associated with the disaster, recurrent and intrusive thoughts, initial separation difficulties and sleep problems. Aptekar and Boore (1990) also reviewed the literature on children and

noted that some of the difference in finding are attributable to developmental level, pre-incident mental health as well as the community's ability to provide support, reaction of adults and separation from parents.

Suedfield (1997) argues that those studying disasters have emphasized the negative impact of exposure to traumatic events, "pathogenesis and distress" (p.851). He notes that the literature is "replete with references to irreparable damage, both physical and psychological and the life-long suffering of survivors of trauma. Suedfeld found generally good adjustment among those who survived aerial bombardments and the atomic bombing of Hiroshima and Nagasaki. He also cited literature of long-term studies of Vietnamese and Laotian Boat people and noted that 40% reported no worries of any kind. Studies of Holocaust survivors have also noted that many have adjusted well in the years following their victimization.

Finally, McMillen (1999) suggests that survivors of difficult and traumatic events frequently report positive benefits from their experiences. His review of the literature indicates that between 45 and 90% of those experiencing adversity report some benefit from the experience. Perceiving the benefit from the experience decreased the probability of experiencing PTSD and other mental health problems. Among the benefits in various studies were changes in life priorities, increase in sense of self-efficacy, enhanced sensitivity to others, improve personal relationships, enhanced sensitivity to others, increased spirituality, finding a new cause, financial gain and increased opportunities (p. 458).

While there is some disagreement as to the specific risk factors and types of impact related to disasters including mass victimization, it is clear that at least some of those who are most impacted will experience great psychological difficulties.

RESPONDING TO CRIMINAL MASS VICTIMIZATION

An increase in the number of mass criminal victimizations as well as recognition of the impact of these disasters have led to numerous attempts to manage their consequences. General recommendations for recovery components and strategies have been offered as well as a large number of techniques concerning specific individual, group and community interventions. Research support for these efforts has varied and the controversy concerning their efficacy continues.

Barnett-Queen and Bergmann (1993) have described four components of recovery after exposure to trauma. These include:

- O **Support** – via the family, community, professional helpers and others
- O **Information** – about the event and possibility of the development of psychological consequences
- O **Ventilation** – through writing or discussion or other means
- O **Coping Skills** -- the development of specific skills to manage the event

A training manual used for the preparation of community crisis responders developed by the National Organization of Victims Assistance (1991) includes the following general strategies for responding to survivors of trauma. These include providing:

- O **Safety and Security** – viewed as a primary issue which must be addressed first
- O **Ventilation and Validation** -- “telling the story” is viewed as important and validation occurs when reactions to the incident are viewed as normal
- O **Prediction and Preparation** – practical and emotional consequences which are predicted are more likely to be controlled and managed. (p. 90)

Holloway & Fullerton (1994) have argued that recovery from terror requires addressing the following aspects of the experience:

- O *Meet the physical needs of survivors.*
- O *Provide a safe environment to restore a sense of safety.*
- O *Provide support, protection, containment and structure*
- O *Allow for opportunity to recognize and express anger.*

- O Attend to the impact of pre-existing psychological problems.*
- O Provide an opportunity to regain a sense of self-esteem and control over life*
- O Provide support from those who provide rescue and other services.*
- O Second injury*
- O Validate feelings and normal responses to an abnormal situation*
- O Provide the opportunity to reassess life goals (p. 42)*

There have been efforts to prevent the development of psychological consequences of disasters. Myers (1989) notes that a critical issue in prevention is the “definition and recruitment of high risk populations” (p. 194) so that services can be focused on these individuals. She also notes that specific social changes including changes in policy, regulations, legislation, organization of services, altering community attitudes and behavior, the prevention of victimization, involvement in planning facilitating community organization, the provision of physical and psychosocial supplies and actions to encourage healthy disaster coping are all critical for preventative efforts. Interpersonal (face-to-face) approaches to prevention were also cited and include actions pointed to key community leaders who may influence the entire community, anticipatory guidance in groups or via telephone counseling, out-of-the-office outreach, training, consultation and support for caregivers.

Weisaeth (1995) notes that prevention of psychological difficulties after exposure to trauma can be achieved through lowering the number of traumas, increasing the stress tolerance of those whom are exposed and early identification of those who are at risk for difficult symptoms. The author describes a number of studies that suggest that disaster training programs appear to be effective in preventing psychological difficulties for disaster workers and victims. However, he adds that more research is necessary to increase the effectiveness of the prevention of difficulties. Weisaeth also described specific preventative interventions developed in response to a major oil rig disaster. The interventions included the development of an information and support center providing the following services

- O Rapid, authoritative information about survivors*
- O Support and a holding environment to impacted persons*

- Serve as a meeting place where individuals and families can meet
- Allow the collection of information by police and other officials
- Site for police questioning, if necessary
- Reduce congestion by having a centralized meeting location
- To provide initial assessment for those who might need psychological treatment

The author also identified a number of levels of support that were necessary for a complete preventative response. These include self-help, a social network of survivors, helpers outside of health care and social services, general and specific medical services, mental health professionals and traumatic stress teams.

A number of writers have suggested general strategies to improve the response to traumatic events including mass criminal victimizations. Stein (1997) described his work after a bombing in Buenos Aires and noted that it is important to use a community orientation when responding to traumatic events. He notes that trauma response teams should not appear to be lead by outside experts who have come “to save them or teach them what to do” (p.113), that outside providers should always work within the presence of local people, cautioned that outsiders should not antagonize local providers and must be aware of the possibility of scapegoating outsiders.

NOVA (1991) notes the importance of attending to cultural differences when providing trauma response services and suggests that many interventions and training materials may include biases and inappropriate language. The authors also argue that it is critical for all those providing services to learn the traditions, beliefs and rituals of those with whom they will be working. Cohen (1992)) suggests that all those working with disaster survivors build a transcultural perspective and understand the cultural factors that impact the provision of crisis intervention services including migration and citizenship status--level of acculturation, gender and parental roles, religious belief systems, child-rearing practices and use of support systems.

Wright and Barton (1994) also provide some general guidelines for trauma response. These include the use of:

- O Public announcements/appearances provides to provide information and reestablishes a sense of control*
- O Press briefings to reassure families and dispel rumors*
- O Organize memorial services to demonstrate a respect for the dead*
- O Attend funeral and public grieving to give others permission to grieve*
- O Describe the loss in positive terms helps to redirect energies into rebuilding*
- O Delegate and trust others to do fulfil their responsibilities.*
- O Outlines goals for the future to reorient thinking*

Omer and Alon (1994) have summarized their approach to trauma response based on continuity theory and suggested the following general techniques for trauma response:

- O Maintain contact with families and other groups to keep all involved*
- O Convey belief in a quick return to functioning as expected and possible*
- O Deliver of timely, specific and concrete information*
- O Counter view of survivors as irrational and pathological*

Stein (1997) notes a number of techniques utilized to respond to Israeli bombing attacks including the creation of hotlines and “information bureaus”, accompanying family members to the morgue for body identification, mental health professionals appearing in various media outlets as experts in psychological trauma and influencing media to moderate sensationalism.

McCarroll et al, (1992) were involved in the Souix City airliner crash and noted that it is critical not to rely on “one- shot interventions”. They also suggest that the response should be determined by the extent of the trauma, nature of groups, impacts, types of difficulties observed, frequency of requests and evidence for the onset of recovery. Butcher and Dunn (1989) were also involved in the response to an airline disaster and suggested that a triage center be set up near the site of the crash for survivors no longer needing medical first aid. They also stress the importance that a family area be provided for waiting family and friends and the need for standby counselors to provide immediate

mental health services.

deVries (1995) notes the importance of responding on the level of the community and notes that research is now clear that social life “may either buffer or worsen the impact” (p. 388) of traumatic events. The author emphasizes the importance of “idiom, ritual and symbolic places that are needed to reestablish community life during crisis and afterwards, the legitimization of individual problems by the medical system that introduces the problem into social life, the role that filial-kin responsibility and the indigenous social security system play in facilitating kin community responses and lastly, the stimulating of self help, therapy maintenance and a focus on problem solving after the disaster has ended”. The management of traumatic events must use the social structure and emphasize the need for the development of new strategies to manage disasters in culturally diverse situations.

A publication of the National Association of Crime Victim Compensation Boards (1999) reports on the special efforts of various governmental agencies after the Oklahoma City Bombing. These include outreach efforts to insure that identified survivors knew about the availability of the crime victims compensation program, the modification of the application and additional funding made available on the federal level. The authors also suggest ongoing coordination with key programs and officials, advance preparation, moving compensation staff to the site of the incident, making early decisions about eligibility and identifying sources of outside assistance in the form of services and donations.

Allen (1993) describes the mental health services provided to the community after a natural disaster, the 1989 Loma Prieta Earthquake. He notes the importance of abandoning the traditional modes of providing mental health services which emphasize individual, office-oriented services. Three tiers of interventions are described by the author. Crisis intervention and debriefing services assist clients in reducing “alienation”, make contact with other survivors and increase the chances of normalizing symptoms by experiencing similar reports by others. Community-based services form the second tier and relate to outreach provided to groups that existed before the disaster. Finally, the last

intervention tier involves the use of all forms of the media to educate concerning the normal symptoms that follow disaster, the availability of services and publicity for large educational events. In a similar article, Terr (1992)) describes the use of three types of interventions. Mini-marathons are three hour large group sessions in which all participants are encouraged to disclose their feelings and symptoms. In addition, those present have the opportunity to compare with symptoms to others and share positive stories about the outcome of the disaster. Educational interventions refers to those services provided to schools and include ceremonies for large groups of children, the use of individual and cooperative art work and discussion by teachers. The use of media include radio talk shows, providing information concerning symptoms and coping skills to media outlets and articles written by experts.

After reviewing the impact of disasters on children Vernberg and Vogel (1993) reviewed a wide array of options that have been used with children to manage a variety of disaster situations. For ease of presentation, they are listed here.

A. Activities Used Disaster Preparation

- Reduction of physical danger to provides perception of increased control
- Education regarding psychological responses
- Preparedness curricula for disaster workers to use with children
- Disaster preparation for children

B. Activities for Immediate Disaster Impact

- Consultation with political leaders and disaster management officials
- Experts /consultants train other helpers or provide intervention services
- Provision of good information with frequent updates to children about nature of disaster.
- Efforts to immediately reunite family members
- Hotlines
- Assistance with or provision of death notification

- Consultation regarding information given to parents when children are impacted
- During times when waiting required, provide ongoing information to parents and acknowledge legitimacy of anger and worry, set limits and use natural support systems.
- Careful notifications for other children about injury or death
- Crisis intervention with mental health professionals for more impacted individuals
- Group interventions focused on ventilation and acknowledgment of strong feelings, provision of factual information

C. Activities used for Short Term Adaptation Phase

- Use of classroom interventions (natural setting and to build cohesion)
- Discussion of recent disaster with possible distribution of newspaper accounts
- Interventions with and without mental health professionals
- Opportunities for nonverbal expression including drawing, stories, music,
- Other techniques including role-playing activities, writing poetry, focused discussions, special class projects
- Small group interventions for high-risk children or those with most symptoms.
- Variations for ages and exposure levels, gender vary
- Family interventions such as family group meetings
- Educational materials such as fact sheets.
- Absenteeism outreach for children who do not come to school.
- Brief family or individual therapy
- In depth, individual, debriefing interviews
- Formal mental health services such as counseling and medication

D. Activities Used for Long Term Adaptation Phase

- Individual psychotherapy of various models.
- Family therapy of various models
- Memorials and other rituals serve several functions including

The most commonly used intervention to response to disaster are group meetings that have been called debriefings, critical incident stress debriefings, psychological debriefings, and others.

One of the earlier attempts to describe debriefings was presented by Mitchell (1983) who described the Critical Incident Stress Debriefing (CISD) as an “individual or group meeting between the rescue worker and a caring individual (facilitator) who is able to help the person talk about his feelings and reactions to the critical incident.” (p. 36). Debriefing types described included the on scene or near scene debriefing, the initial defusing, the formal CISD and the follow-up CISD. The formal debriefing was described as having the following stages: introductory phase, fact phase, feeling phase, symptom phase, teaching phase, re-entry phase.

Other models of debriefing have also been described. Raphael (1986) suggests a number of content areas to be included in debriefings including a review of the positive aspects and feelings; exploration of co-worker and other relationships; the stressors associated with empathy for those helped; transition from rescuer to normal duties and integration of the experience and the identification of effective coping strategies. Weaver (2000) describes a multiple stressor debriefing that includes the disclosure of events, feelings and reactions, coping strategies and termination as well as a community response variation of the CISD that includes an introduction, fact phase, thought reactions phase, emotional reaction, phase, reaffirming phase, teaching phase and Entry phase. Wollman (1991) describes a group process-oriented debriefing use by the Alberta Mental Health Services that include efforts to resolve “themes and concerns” using emotional catharsis, grief work, corrections of unrealistic actions taken during the incident, direction and discussion of avoided issues. In addition, the group is asked to confront topics that are avoided and participate in educational discussions. Bergmann (2000) has continued to refine his debriefing process (1993) and describes the use of two debriefing types. Psychological debriefing are designed to protect all participants by monitoring and limiting the description of graphic material and focuses on cognitive management, information, coping skills training and assessment of those requiring further services. Educational debriefings are more didactic in nature and include statements from those with intimate knowledge of the disaster,

normalization of symptoms, a review of coping skills and the availability of further services. Both models stress the likelihood of successful management of the incident.

Shalev et al (1998) noted the difficulty in studying debriefing because of the large number of models used for this intervention. The authors studied a group of soldiers who participated in an “historical group debriefing” after combat exposure. Results indicated that those participating in this intervention reported reduced anxiety and self-efficacy. In their conclusion the authors note that debriefing interventions are best viewed as “stress management techniques, rather than as preventative interventions” (p. 497) and called for further research to determine the specific components of debriefing which may be helpful after traumatic exposure.

The International Critical Incident Stress Foundation (1997) summarized a number of studies of the effectiveness of debriefings. Included in this list were studies that showed positive perceptions of CISD, a lower level of depression and stress three months after participation in debriefings and a reports that participating was important in managing feelings after exposure to trauma. Carlier et al (1998) note a high percentage of satisfaction with debriefing among participants including 68 percent of disaster victims reporting the helpfulness of the intervention, 81 percent of fire victims and a majority of health care workers who were “happy” with debriefing.

There is also a growing concern about the effectiveness of this intervention. Raphael and Meldrum (1995) note the lack of systematic evaluation of the debriefing process. While participants often report that the intervention is helpful, some research indicates that debriefings may not assist in recovery. The popularity of the technique may be due in part because, “it meets many needs, the needs of those not directly affected to overcome their sense of helplessness and the guilt of surviving, to make restitution and to experience and master vicariously the traumatic encounter with death, the needs of those directly affected to speak of what has happened, understand it and gain control and the symbolic need for workers and management to assist those who suffer and to show concern” (p. 1480). The authors also add that debriefing may not be effective because, “it does not take account

of subjects' levels of arousal, defensive styles and coping process, cognitive impairments associated with acute trauma, dissociative phenomena relating to the traumatic experience and other pathogenic influences such as past trauma, past psychological morbidity and current and recent life stresses" (p. 1480).

Hamling (1997) notes his disappointment with the poor findings from the debriefing literature and writes that he has observed, "the almost instantaneous reduction in post-traumatic stress symptoms.... during a debriefing session" (p. 4). He writes that it is possible that debriefings are being overused or being used without other stress management techniques. Hamling also suggests that providing debriefing services immediately after a disaster may not be helpful and that survivors should initially use their own coping skills.

In a longitudinal study of police officers who were and were not participant in debriefings, Carlier et al (1998) concluded that there was no difference among the groups eight months after the potentially traumatic incident. Those that received this intervention had were more likely to report symptoms of posttraumatic stress disorder eighteen months after the incident. Specifically, these most impacted individuals reported significantly more hyperarousal symptoms than non-debriefed participants. In their discussion, the authors suggest that it is possible that debriefing participants are more likely to be comfortable reporting symptoms, are overwhelmed by this intervention and the emotions that are released or that the debriefing began to early.

In their review of the use of debriefings, Dunning and Stuhlmiller (1998) note a number of difficulties with this intervention. These include the pathogenic framework assuming that a large percentage of those impacted by an event will develop psychological symptoms, the devaluation of coping skills other than ventilation via talking, the potential ethical problems of debriefings the potential damage that self-focused attention can have on recovery and the possibility of overexposure of debriefing participants who hear other discuss the incident. The authors suggest a radical change in the models used for addressing trauma and suggest that intervention should convey the great likelihood that

recovery will occur as well as the likelihood that traumatic events can result in growth. They also encourage all those involved in trauma response efforts return to the literature in an attempt to more completely understand the nature of trauma and recovery.

In a more rigorous review Rose and Bisson (1998) reviewed the six studies that fit a complicated set of scientific criteria. Of the six studies, two found “some evidence for a positive outcome, two demonstrated no overall effect and two found some negative effects.” (p. 705). The authors conclude that there is “little evidence that early intervention prevents psychopathology following trauma.” (p. 707). They also noted that the perception of positive outcome is not sufficient to justify its routine use and they called for further rigorous studies to be conducted.

In part as a response to the criticism of the CISD intervention, Mitchell and his associates (Everly & Mitchell, 1999) have developed Critical Incident Stress Management (CISM), “a comprehensive, integrative, multi-component crisis intervention system” (p.1). Among the interventions utilized in this system are stress management education, stress resistance and crisis mitigation training demobilization, informational briefings, town meetings, defusings, critical incident stress debriefings, one-on-one crisis intervention or counseling, family crisis intervention, follow-up and referral. The authors also site several outcome studies with positive results.

Some have altered the CISM process to fit their organization’s need. Zanger (2000) describes the problems of providing services to Navy personnel deployed on ships, the culture that suggests that outside resources are not necessary on ships, lack of mental health providers and rotation of those who might serve as “peers”. Modification of program components included the use of chaplains as primary providers, organization by Battle Group, assignment of an aircraft carrier mental health professional as the Clinical Director and maintaining flexibility in the timing of debriefings.

In an article with obvious implications to the response to mass criminal victimization, Paton et al (1998) attempts to explain the problems with debriefings by observing the organizational factors that

impact recovery. The authors notes that “traumatic stress reactions cannot be attributed solely to exposure to a specific traumatic incident” (p. 3) and stress the importance of the interaction between the event, culture, organizational memberships and other variables. As a result interventions must include consideration of roles, social norms, vulnerability, social identity and other factors.

There have also been other efforts to integrate information from the contingency management and disaster literature. For example, Carter (1991) has described the implementation of “humanitarian assistance” efforts to facilitate the recovery of the organization and community after a disaster. He describes the basic steps to developing a complete humanitarian assistance approach including the creation of a policy that describes the services to be provided to employees, contractors and community members after a disaster, an emphasis on the participation by those at the highest levels of management, the identification of all those emergencies to which an organization is vulnerable and the setting performance standards for all interventions. Carter also argues that each department within an organization should have input into the plans for their area. The plan should include the following components:

- O Notification of an emergency will trigger implementation of the program
- O Development of an organizational structure and the staff to deliver the program
- O Development of procedures to deliver services and benefits
- O Development of planning committee with participation by senior management

Training as well as detailed exercises should be developed to both inform personnel of the humanitarian assistance plan and to allow practice in service provision.

Citing the difficulties with research in the debriefing literature, Bergmann (1999) notes the potential value of a “menu” approach to trauma response. In this model, the characteristics of the event are matched to the needs of the various high-risk survivor groups. Each intervention is planned on an individual basis and may include one or more of the following interventions:

- O *Initial telephone consultation and assistance*
- O *Telephone availability*

- Telephone check-in
- Provision of humanitarian assistance
- Immediate on-site response
- Initial on-site meetings
- Crisis intervention
- Debriefings
- Final on-site meetings
- Counseling
- Follow-up meetings and debriefings
- Telephone follow-up
- Return to work/school efforts
- Memorial/anniversary assistance
- Evaluation

The author describe responses to mass criminal victimization using these interventions.

There have been recent efforts to describe the response to disasters on a community level. Milgram et al (1995) note that such efforts “are a complex difficult task for well-intentioned and well-trained ‘insiders’ trying to help people in their own community with whom they share language, culture and values”. They note that such efforts are much more difficult when provided by outside experts or agencies. Among the recommendations include:

- The use of key informants in the community in order to understand intervention timing
- Correct identification of those who are able to provide support
- Understanding the impact of similar and different values among the communities impacted by the disaster

A major recommendation by the authors includes the use of the use of information to facilitate the recovery process. By identifying and communicating an “existential healing context”, support for survivors is mobilized. For example, the media can be used to educate the public about the

destructiveness of excessive anger and other feelings. In addition, people are more likely to volunteer if they are given clear and precise instructions and aware of the actual needs of those impacted and the media is also a good way to describe the economics of recovery as well as information about any available compensation or other assistance. Certain thoughts have been found to be helpful in recovery and the media can also facilitate their dissemination. These include contrasting the current situation with those who are less fortunate, imagining a worse situation, emphasizing the normalcy of emotional responses and identifying benefits that can come out of the disaster.

Advice for organizing mental health responses for mass criminal victimizations were offered by Pfefferbaum (2000) who participated in efforts to assist survivors of the Oklahoma City bombing. She suggests that it is important to determine the appropriate role for agencies and institutions and that coordination is critical during the initial days after the incident. Gaining funding is also an important issue and the author reports the Federal Emergency Management Agency was a key supporter of service provision. Survivors developing more serious mental health symptoms require more than crisis intervention and referral mechanisms must also be developed. Pfefferbaum notes that many professionals provided low or no cost treatment after the bombing but that funding remains an issue today. Training and consultation is also required to insure that the most effective services are provided and research should be considered to further our knowledge of mass criminal victimization. Tucker et al (1998) described the special challenge of coordinating services after mass criminal victimization and note that "terrorism necessitates a healing environment of social cohesion to prevent panic and social disintegration" (p. 94). Such cohesion must also apply to the various groups of providers involved in this effort who may have not previously worked together. Different groups may bring very different orientations and treatment approaches and "can cause potentially damaging disagreement(s) among service providers" (p. 95) and efforts to provide the opportunity for joint education and discussion may be helpful. Among the specific interventions provided the community was a toll-free hotline for crisis counseling and referral, mobile outreach, debriefings, consultation from experienced groups and others. All research efforts were also coordinated to insure that there

was no duplication and human subject protocols were closely followed.

While trauma response efforts are well accepted in the response to disasters and mass criminal victimizations, there are still major questions about some commonly used approaches and interventions. Major planning and intervention efforts should be carefully tied to our formal understanding of trauma and recovery.

PLANNING FOR RESPONSE TO CRIMINAL MASS VICTIMIZATION

Every since the ant admonished the grasshopper to prepare for winter, the value of preparation for potential disaster has been understood. Today, most large public and private organizations have some type of disaster or emergency management plan in place. However, these plans have primarily focused on the operational response to natural disasters and industrial accidents and have largely ignored the human impact of disasters and those of mass criminal victimization.

A number of sources focus on the importance of planning for effective disaster response. Guhi-Sapi (1991) wrote that “approaches to relief remain largely ad hoc and amateurish, resulting generally in inappropriate and/or delayed action”. Oster (1997) argued, “The solution is not found by waiting for a disaster to strike before figuring out a plan. The time to plan is now” and Meyer & Graeter (1995) note that the response of a crisis is a “complex interdisciplinary project that requires a strategic management framework to facilitate development of high quality, cost effective programs”. In their comprehensive text concerning planning and crisis management, Nudell and Antokol (1988) wrote,

We contend that true crisis management is more than reflexes and luck. While in many ways it is reactively oriented, effective crisis management is a collection of anticipatory measures that enable an organization to coordinate and control any emergency.... We believe that the best crisis managers are those who are also involved in the contingency planning process that should precede any emergency... (p. 21)

The authors continued by identifying a “crisis management pyramid” that includes the following components:

- O Senior management’s willingness to think about the unpopular and recognize the possibility that a disaster might occur.*
- O Recognition of the dangers and opportunities crises brings.*
- O Definition and control of the crisis responses via planning, training and practice.*
- O Harness the environment by delegation, organization, and appreciate of the stresses involved in managing events.*
- O Contain the damage including the emotional and public relations components.*
- O Successful resolution meaning that the organization leaves the crisis in a nearly identical condition that before the crisis.*
- O Return to normalcy by planning for an orderly resumption of normal operations and assistance all personnel.*

Moore (1997) describes a “successful planning methodology” that includes prevention, response, resumption, recovery and restoration and describes the steps necessary to create such a plan. These include project initiation, the business impact analysis, plan construction and exercising and maintaining the plan. In another article by the author (1996), she stresses the importance of insuring that the disaster plan works for many different types of events and impact and often overlook areas including the possibility of delayed access to the site of the disaster, the ability to relocate important organizational functions, consideration of emergency authorization when organization leadership is impacted or not available, the proper insurance and public relations and a complete command center.

Harris (1997) argues that the organizational culture is a critical component of crisis management and disaster recovery. He explains that many disaster recovery planners overlook the importance of gaining support from all levels of the organization including middle management, line workers and supervisors and suggests methods to create a more positive disaster management culture. Included in these suggestions are the involvement of as many staffs and organizations as possible, mentioning disaster planning in every meeting, develop a business impact analysis, collect and distribute disaster-related article and distributed them widely, present disaster management to many different

levels of the organization, and create a policy statement for top management's approval.

Frishberg (1999) stresses the importance of proper exercising to maximize the useful of resources utilized for disaster planning. He describes a suggested exercise "planning schedule" that includes the plan, exercise development team, establish exercise framework, scope the exercise, establish exercise objectives, refine exercise targets, establish exercise scenarios, develop exercise structure, develop exercise structure, conduct the exercise, post-exercise debriefings, collect and analyze evaluations, issue exercise reports, improve the plan and automate exercise development.

Doepel (1991) argues that a critical component of crisis management has been ignored and notes that while surveys indicate that as many as sixty percent of companies have crisis management plans, most of these plans are devoid of "clear guidelines for dealing with the inevitable and often severe stress reactions that employees and management personnel may experience" (p. 178). He cites the needs of managers to understand and plan for the psychological dimension. It is also likely that those in the public sector may also need to place an increased emphasis in this area.

Carter (1999) also emphasizes the importance of considering "human needs during disaster planning and suggests the following components necessary for planning for effective humanitarian assistance including analyzing your current state, make policy a priority, organize the response and train the team. Paulk (1998) makes a similar argument and notes that the plan should include steps for preparedness, response and recovery. Preparedness should include the following components; assemble a crisis management team, train employee representatives, educate management and employees, pre-arrange outside professional assistance and train management in response capability. Response should include guidelines for a structured management response, provide psychological first aid, provide management-led de-escalation meetings, contact family members of casualty victims, protect employees from the media, plan media communications, coordinate telephone operators, assess the need for trauma response interventions, identify at risk employees, provide management briefings for returning employees and maintain communication with employees.

Recovery should include continued two-way communication with employees and vigilance to identify employees who might continue to require assistance.

Milgram et al (1995) note that most planning processes include the production of a comprehensive survey of the various organizations with responsibility to respond to the disaster and how these groups will cooperate. The result of this process, the authors suggest, should include the following:

- Existing organizations should do what they do best, if what they know best is needed.
- Existing organizations should be encouraged to acquire new skills or modify their repertoire to better serve survivors.
- As a last resort, ad hoc organizations should be created to deal with special requirements. (p. 479)

Gillespie and Murty (1994) describe the problem of “cracks” (“missing services, inaccessible services, administrative oversight, inappropriate referrals and missing information” (p. 640) in the post-disaster service delivery system and the critical importance of the planning process. The authors state that planning for the delivery of services makes them “more accessible, reduces duplication of service and prevents or eliminates cracks in service delivery” (p. 641). Planning can be made more difficult by a number of factors including services crossing different professions, organizations and jurisdictions, limited resources, and organizations wanting to be self-sufficient. The authors suggest the use of a “network analysis” to assist planning groups to identify cracks in services and then charge planning groups with eliminating them. Interventions can be targeted to cracks so that services can be integrated, communication improved and resources distributed more effectively. A recommendation is also made to target the peripheral and isolated organizations to encourage them to actively participate in the planning process.

Perry & Nigg (1989) observe that “planning is equated with developing a written document and preparedness is conceived as a product of written plans” (p. 352). They note that research shows that this is an inadequate view of disaster planning and suggest that planning is a process, “a collection of documents, agreements, interpersonal and interorganization relationships and activities

that are both perceptual and ever-changing” (p. 352). Disaster planning includes three objectives; risk identification, risk assessment and risk reduction and note the characteristics of effective emergency planning.

- H *Emergency planning is a continuing process and is never “completed”. Social physical and technological considerations are constantly changing and so should the plan.*
- H *Effective planning emphasizes the appropriate actions and interventions to be used. Threat assessments must be performed continuously and effectiveness should not be replaced by speed.*
- H *Planning should be flexible so that all those involved can adjust to needed demands.*
- H *Planing has an educational component involving the public, administrators, workers and all audiences.*
- H *Planning should be based on accurate information concerning the threat and likely human responses.*
- H *Planning should address organizational issues including the coordination of all those with responsibilities for managing the disaster.*
- H *Planning is almost always implemented with resistance including the public’s hesitancy to think about disaster and official’s hesitancy to use resources for planning.*
- H *Planning should include tests for the proposed response operations including drills and simulations.*
- H *Planning should be an integrative approach and generic functions across many disasters should be identified.*
- H *Planning is not management and these two functions should not be confused. (p. 262)*

The authors also describe the outline for a general disaster plan to include; the authority of the plan, aim and scope of the plan, a hazard or vulnerability analysis, a recounting of all reciprocal agreements, provisions for testing the plan and administrative issues. Activities that are appropriate across disaster types include a warning system, evacuation procedures, victim shelter and welfare, emergency medical care and morgue, search and rescue, damage assessment, security and property assessment, public information and the establishment of an emergency operations center (p. 367).

In commenting about responses to disasters including mass criminal victimizations, Vernberg and Vegel (1993) said, “Planning is generally more advanced for natural than human-made disasters and

more elaborate for meeting the physical versus the psychological needs of the community” (p. 486).

A federal program dealing with a form of criminal mass victimization (child abduction) was the Missing and Exploited Children Comprehensive Action Program (M/CAP) of the Office of Juvenile Justice and Delinquency Prevention (1989). This program emphasized cooperation among disciplines to coordinate community services in complex issues related to missing and abducted children and their families. Teamwork, commitment and coordination were stressed to reduce duplication, confusion over resources, reduce overwork among staff, and increase the availability of services. Communities that based their response to missing and children on a long-range strategic plan developed through a multidisciplinary collaborative effort were able to sustain their initiative.

While planning can be a complicated process, the experience of those working in different organization and type of disasters all argue that it is absolutely critical for effective response.

SUMMARY AND CONCLUSIONS

Given the review it is possible to make the following general conclusions about the nature and impact of exposure to criminal mass victimization.

- ! Criminal mass victimization is an extreme form of man-made disasters which include many of the risk factors for difficult impact
- ! A significant minority of those impacted by these events will develop difficult adjustment consequences. Those with certain risk factors are more likely to experience these problems
- ! Children are at high risk for the development of difficulties after disaster and experience problems that are closely tied to level of development.
- ! A number of general factors have been identified as necessary for recovery and these have been utilized in a wide array of trauma response techniques and approaches
- ! There is no consensus about the utility of group meetings or debriefings as a primary intervention tool
- ! Planning plays a critical role in the development of effective intervention approaches
- ! Preplanning and identification of community resources is critical to a community's effective response to a criminal mass crisis
- ! Few communities, if any, have the resources necessary to independently cope with an act of criminal mass victimization
- ! Communities must be prepared to sustain themselves in the short-term and long-term phases of recovery from an act criminal mass victimization
- ! Services to are more readily accepted and trusted by the victims when the delivery mechanism is locally-based and managed

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