BEYOND THE VICTIM: THE TRAUMATIC EFFECTS OF VIOLENT CRIME – AN EDUCATIONAL PSYCHOLOGICAL PERSPECTIVE

By

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DECLARATION

I declare that "Beyond the victim: the traumatic effects of violent crime" is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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November 2002

SUMMARY

Violent crime is among the most prominent distinguishing characteristics of South African society, it has a severely traumatising effect on the populations concerned. Based on research findings and existing literature, this study explores traumatic effects of violent crime on the most intimate associate of the victim (the partner). Accordingly, this study deals with the much-neglected topic of secondary trauma, by focusing on the following aspects of or conditions associated with violent crime and the secondary victim: cognitive, emotional and relational effects the experience of trauma, loss, vulnerability, depression and acute stress. It reveals that, depending on the severity of the incident, its consequences for the partner of the victim may range from post-traumatic stress to acute stress or secondary traumatic stress.

From the similar results returned for primary and secondary victims, it is apparent that in the future, both victim and supporter should have their needs addressed with equal emphasis.

TITLE OF THE DISSERTATION:

Beyond the victim: the traumatic effects of violent crime – an educational-psychological perspective.

KEY TERMS:

Crime; armed robbery; carhijacking; secondary victim; traumatic effects of violent crime; loss; vulnerability; depression; acute stress disorder.

Dedication

This dissertation is dedicated to my husband Thane and to my late friends Dr Sigo and Charmaine Nielson.

ACKNOWLEDGEMENTS

Every person passing through this life will unknowingly "leave something" behind and "take something" away. Most of this "something" cannot be seen, heard or numbered, but nothing counts without it.

I would like to express my sincere gratitude to the following people for their contribution to the success of this study:

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Ns = non-significant S = significant

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"They had been initiated into the strange twilight fraternity where explanation would be forever impossible. Everybody understands this, as they did themselves, dimly. It did not need to be mentioned. Everyone was sorry, as they were themselves. However, there was nothing that could be done about it. Tenderness was all that could be given, and like most of the labelled human emotions, it meant nothing when put alongside the intensity of the experience" (Author unknown).

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTORY ORIENTATION

South Africa, land of sunny skies, braais and murder - (Daily News - July 2001)

2001 The Year of Living Dangerously - (Sunday Times - Dec 2001)

SA crime causes stress in schools (Citizen – October 2002)

Hijacked twice in one day - (Citizen - Jan 2002)

Boy 10 Jailed for rape of girl - (Star - Dec 2001)

Change of official tourism policy in South Africa - (Pretoria News – Nov 2002)

(tourists warned of exposure to violent crime in the country)

Newspaper headlines such as these shock law-abiding citizens everywhere. One need only read case studies behind these headlines to feel the urge to act for and assist people affected by this type of violent, traumatic incident.

Such a sudden, human induced traumatic experience can shatter peoples' lives and leave a profound mark on the way they feel about themselves and others. The traumatic effect of violent crime can leave a lingering feeling that life and the world have changed for the worse. Despite media reports and warning signs around neighbourhoods where violent crime is prevalent, people do not want to believe that it could happen to them, perhaps because the warning signs, if heeded, help to generate a climate of anxiety and fear. Then – trauma happens. Suddenly, the slightest problem fills the horizon and there is an overwhelming sense that things are out of control.

" *It is as if your bubble of safety has burst. All the beliefs you held about yourself and your fellow man before the trauma seem to have changed and are no longer felt to be true" (Herbert & Wetmore 1999:1).*

This is the grip of crime-related trauma. Over a decade ago, Holmes (in Parson 1998:270) predicted that trauma and its aftermath would provide one of the most dominant paradigms for psychotherapeutic work. "Five themes will influence the climate of psychotherapy over the next few years: science, religion, inequality, gender and **trauma"**(writer's emphasis).

While this introduction is being written, another carhijacking, armed robbery or some other violent crime is being reported in the South African media. The lists of traumatic incidents is endless. However, this research project is centred on only one of the previously mentioned (Holmes) "big five" – *trauma* particularly that which is *crime-related.* This study challenges research and therapy to explore "beyond the victim" and to gain an understanding of the effects of secondary trauma on those closest to the adult victim, i.e. the partner.

Given the extent and intensity of crime in South Africa, the helping professions are in the unique position of being able to contribute to the South African community as a whole, particularly since they tend to work with the whole family.

1.2 ANALYSIS OF THE PROBLEM

1.2.1 Awareness of the problem

The focus of this project arose out of the researcher's interest in the increasing number of reported carhijackings and other crime-related traumatic incidents. People seemed determined not to show the world how such traumatic events had affected their lives. Victims bravely carried on as if nothing had happened, dealing with the situation privately and to the best of their ability. Counsellors of highly traumatised refugees from oppressive third world regimes found that people this traumatised were ashamed to talk about their experience because of the profound insult to their humanity, and that as a first step toward self-healing they had to be coaxed and coached to become angry and vociferous about the outrage they had suffered at the hands of their tormentors.

After being privy to reports of traumatic incidents by pupils, parents and colleagues (in the researcher's position as counsellor at the school and as a trauma-debriefing counsellor at a crisis centre), no matter how "brave" victims appeared to be, their lives seem to remain forever indelibly affected. In some cases this meant life-style changes in the form of improved

security, electric fencing, moving to cluster homes, "guard" dogs and, in extreme cases, the purchasing of weapons, or even emigration. It would also seem that the trauma experienced by the victim was not an isolated event, but had important ramifications for his/her partner.

Visits to the "Traumatology Association of South Africa" and the "Centre for the Study of Violence and Reconciliation" showed that carhijacking and armed robbery were the most frequent reasons for referrals to the trauma clinics. These visits plus discussions with a research psychologist specialising in trauma on the gaps in South Africa's knowledge of trauma induced by violent crime - particularly for the secondary victim – heightened the researcher's curiosity about this phenomenon. These two things gave rise to the first questions for this study: What about the primary caregiver as a secondary victim? What impact does trauma have on this vital support structure? Do their own related issues render them ineligible to help the victim? How and to what extent is the partner "infected"?

The "infectious" nature of trauma for the secondary victim has come to be known as secondary trauma. It is the least known of all traumatic stress, and although researchers such as Figley (1995:8) and Pearlman (Conrad & Acker http://www.chidtrauma.org/apsac.sec trauma.htm) have highlighted some of its traits, the most elementary question remains unanswered.

> **To what extent is the traumatic stress/trauma first experienced by the *"primary victim"*, also experienced by the closest supporter of the victim, i.e. the *"secondary victim"?***
>
> Figley (1995:249)

He states that in order to address the above issue therapists require a description of the effects of trauma for both those *"in harm's way"* **and** those *"who care for them"*. (Refer to Table 4.10 for a description of the traumatic stress symptoms – found in this study).

1.2.2 Exploration of the problem

Crime has transcended race, age, social status and religion to encompass *all* in its heinous embrace. In exploring the general problem of trauma within the South African context, the researcher considered the following four factors:

Firstly, the magnitude of victimisation; secondly, the given reasons for the present violence and crime; thirdly, the cycle of violence; and finally, the theoretical underpinnings which will be discussed to explain the effects experienced by the secondary victim after a traumatic experience of violence.

1.2.2.1 *The magnitude of victimisation*

The number of people experiencing trauma is on the increase, reaching alarming proportions in South Africa. In 1999 the Minister for Safety and Security stated that 188 out of every 100 000 South Africans were victims of either armed robbery or carhijacking (Hamber 2000:8). Nowadays, the experience of being violently victimised in South Africa has almost become a statistically normal feature of everyday life. Statistics reported in 2001 (Meyer http://www.iol.co./index.php/click=13) show that one in sixty-three people are victims of violent crime. The article reports that South Africans are more likely to die of a gunshot wound than in a motor-vehicle accident.

In comparison to the 1999 government statistics those released to the researcher by the South African Police Department in December of 2001 were 25 in 100 000; which implies that there has been a decrease in the present crime rate. However, statistics generally indicate national averages which are often disputed and are notoriously unreliable in South Africa (Hamber 2000:8). In reality the probability of being victimised is increasing, according to the researcher. Crime-related violence and trauma impact on every front in people's lives: politically, socially, economically and physically. "This trauma takes its toll on all of us" (Stucky 1998:3).

A comparison between Northern Ireland, where 2 847 people have died due to political violence in the past two decades, and South Africa, where 21 000 were killed in violent crime

in one decade, serves as an indication of the intensity of violence in South Africa (Pelser & de Kock 2000:81). On the social front, South Africa experienced a net loss of people due to emigration during the period 1994-1997 that equalled the total incidence of mortality for the Second World War (Pelser *et al* 2000:89). The "culture of violence" was cited as one of the primary reasons for the decision to leave the country. The World Economic Forum says South Africa has an "organised crime" problem second only to Colombia and Russia (Butcher 1998:9). Trauma injuries cost the country millions of rands. Two programmes were budgeted for by the South African police department in 2002 to deal with victims of crime namely, "the victim empowerment programme" and "the victim support programme". The cost of these programmes to the national budget could not be released to the researcher by the police department. To make matters worse, Trevor Manuel (South Africa's present Minister of Finance), warned that South Africa's crime rate might remain above international norms for another six to seven years (The Citizen 2002, Feb 4).

The magnitude of victimisation and violence as reflected in the above statistics, is difficult to comprehend. It is easy to respond with denial, detachment and intellectualisation as a defence against the emotions that are aroused by this knowledge. It is difficult to empathise with statistics (Mc Cann, Sakheim & Abrahamson 1988:535). However, individual human beings are represented in these figures, human beings who clearly suffer significant emotional, cognitive, physical or interpersonal scars from their traumatic experiences. These scars are often invisible, yet as this research study proposes, profound effects persist not only in the lives of victims but also in those close to them. The implication of this proposition is far-reaching as it assumes that the already alarming statistics are underestimated due to the exclusion of the "hidden" secondary victims.

Against this background, a synopsis of the reasons given for violence in South Africa is imperative. This will shed some light on the background to crime and violence in South Africa and will facilitate the readers' understanding of the effects of secondary trauma as discussed in chapters two and four.

1.2.2.2 *Reasons given for violence*

Some of the reasons suggested for violence include: apartheid, racial slogans, lack of education and values, social disintegration, economic decline, housing problems, rising unemployment and the increasing number of illegal aliens.

It may be hypothesised that crime is out of control due to South Africa's political history. This statement is supported by research (Pelser *et al* 2000:81) that has shown that violence has a developmental history. The South African community has been struggling for decades to remove the effects of the laws of apartheid from South African society. The effects of apartheid were expressed in gross injustice in the form of discrimination against people of colour as regards education, housing, health care and employment. The effects also took the form of forced removals, which meant destruction of social networks, norms and trust that had been built up over time. In turn this resulted in a lack of sound education, values and morals, so that parents raised anarchists who typically produced the destructive pre-1994 slogan of the ANC: "*First liberation then education,"* which also took its toll. The underlying philosophy of "take, even if you have to destroy" serves as an example of how children were encouraged to disrupt and destroy. Chikane (in Burman & Reynolds1986:344) wrote that, *"...the most tragic reflection of the war situation in which South Africa finds itself, is that it faces the years to come with children who have been socialized to find violence completely acceptable and human life cheap".* Again, McKendrick and Hoffman (1990:26) claim that "violence inverts value systems and makes maiming and killing socially acceptable". This would seem to imply that the high incidence of violent crime in South African society might be the result of some, or all, of the following factors. Inhumane acts carried out by law enforcement officers and the state during the apartheid years in the form of states of emergency and detentions without trial, together with the political struggles between parties like the ANC and IFP.

Besides the destructive slogans marking the political transition to a post-apartheid society, a major issue that influences crime and violence in South Africa in the 21st century is social disintegration (Emmett & Butchart 2000:274). The Nedcor Project researchers (1996:3) suggest that societal structures seem unable to cope with the poor socio-economic conditions in South Africa, which has to contend with a surge in the illegal drug trade, economic stagnation, and an ineffective Reconstruction and Development Housing Programme.

A growing body of evidence suggests that the quality of social relations deteriorates and violence increases with deepening inequalities (Emmett *et al* 2000:295). Moreover there is widespread corruption, which has reached staggering proportions in government circles, and the characteristic sexual behaviour that fuels the unbelievable AIDS infection rate in South Africa raises the question whether violent crime is not consistent with a society that produces these phenomena.

Cawthra and Kraak (in Hamber 2000:9) capture the impact of the past on the present as follows:

> *"The decades in which the police enforced apartheid have engendered a mistrust of law and authorities. However, crime is intrinsically linked to poverty, unemployment and socio-economic inequalities. The coalescence of these indices with the brutalisation that many experienced in the apartheid struggle, has given South Africa its particularly violent edge."*

This statement implies the exclusion of other factors, such as those already mentioned, and as such may mask more "inherent" violence hidden under the name of apartheid, thus precluding a proper confrontation of violence. An over concentration on the influence of apartheid persists in South Africa, but it should be borne in mind that history shows the reign of terror of black dictators like Shaka reached legendary proportions. The whole Basuto nation consisted of remnants of tribes decimated by constant tribal warfare. This shows that the history of violence in South Africa began long before apartheid.

The reasons behind the increase in and causes of criminal violence are clearly complex and difficult to probe. As yet they have been insufficiently researched or understood. Nevertheless it is certain that an imbalance in resources and survival needs are a basic part of the problem. The accumulated frustrations and resulting anger are also relevant. In a society where a "culture of violence" has been established through socio-economic difficulties, state policy (both past and present) and the history of resistance to it, these behaviours cannot be shed overnight. Indeed, the use of violence for personal aims has become endemic in South Africa (Shaw 1995 in Louw 1997:138).

1.2.2.3 *Cycle of violence/retaliation*

Hamber (2000:10) asserts that "Victims of criminal violence, if untreated, are at risk of perpetrating acts of violence in the name of '*justice*'". Until now this "cycle of retaliation" has been thought to occur only in cases of abuse. Researchers of criminal violence still seem uncertain whether the cycle is perpetuated in cases of violent trauma. On the one hand, James (1989:148) writes "trauma violates basic trust and interferes with empathy thus removing inhibitions regarding crimes against others." On the other hand McCann *et al* (1988:550) contends "not all victims of violence become perpetrators". The researcher suggests some reasons for the cycle continuing: the first is that there is much underlying aggression in victims, the retaliatory response of the victims may be a way of reasserting themselves in society, suitable deterrents for those who would contemplate a criminal act/s also have to be in place. The absence of these deterrents in South Africa serves as an encouragement to the increase and proliferation of crime. People are losing faith in the authorities' ability to deal with crime and so may resort to taking the law into their own hands. The argument here is that because the secondary victim is part of society, the prevalence of violence in society could be linked to a cycle of violence which involves these "hidden" (secondary) victims. The need for revenge or to see justice done is measured in chapter four as the emotional variable "retaliation".

1.3 THEORETICAL UNDERPINNINGS OF THE STUDY

Although the statistics presented earlier have highlighted how many South Africans become victims of violent crime there is still relatively little rigorous epidemiological data on violence in South Africa (Traut, Boschoff & Hawkridge 1998:16). However, there appears to be a growing awareness of crime-related trauma and its consequences. As a result, sporadic attention has been given to setting up intervention programmes in banks and businesses to deal with the increase in crime-related trauma. Yet no consideration has been given to the people to whom these victims go home.

As early as 1988, Figley appealed to researchers to consider the prevalence of post-traumatic stress disorder or secondary victimisation among the "closest supporters of the victim". He points out that "nearly all of the reports focusing on traumatised people exclude those who

were traumatised indirectly or secondarily and focus on those who were directly traumatised" (Figley 1999:14). Kishur in (Figley 1988:637) stated that "there is a 'chiasmal effect' of the transfer of traumatic symptoms to supporters". He drew the meaning from genetics: *the point of contact between paired chromatids during meiosis, resulting in a cross-shaped configuration and representing the cytological manifestation of "crossing over".* He felt that the term best described the "crossing over" of symptoms from the victim of crime to their supporter. He (1988:637) cites studies by Davis and Friedman (1985) and Kishur and himself (1987), which confirm that family members of victims of crime are affected in ways similar to the victims themselves; however, the studies do not go on to show to what extent a family member is affected.

Other researchers besides Figley have indicated that special attention should be given to the "hidden victims". This secondary victim is one who might seem to have little exposure to the incident, yet could experience the incident as disturbing. Ayalon and Udwin (in Traut *et al* 1998:136) state that "often the person closest to the victim needs therapeutic intervention to reduce his/her own level of post-traumatic stress *before they are able to help* their children, or partner". According to Hyer (1994:109) various authors, such as Rosenheck and Nathan (1985) and Davidson, Smith and Kudler (1989) maintain that the problem of secondary traumatisation after a traumatic event is not only underreported but also carries a social cost. At the same time some acknowledgement has been given to the secondary victim in that descriptions of that which constitutes a traumatic event according to the DSM-IV-TR (2000:467) clearly indicate that simply the knowledge of a loved one's exposure to a traumatic event can be traumatising.

As far back as 1939 a study by Gralnick (Figley 1995:5) showed that a "psychiatric illness can appear to be shared by the patient's spouse". A similar study by Whitmer on Israeli war veterans' wives (http://www.womanabuseprevention.com/html) showed that the loved ones close to the victim are also affected. Indeed Miller (1999:21) concurred that the victim's partner bears "at least some of the brunt of the patient's post-traumatic adaptive struggles". Becker (http://www.berghof-centre.org/handbook/becker/s2) suggests that it is essential for researchers to study this so-called "ripple effect" on the partner as a victim within the family system more closely, in order to truly understand what effects trauma has on the "system". It follows that a broader view of trauma comprising the interaction of related systems would

similarly yield better treatment results. After all, the secondary victims' own related issues within the "system" may render them ineligible to help the victim. The reaction of these systems to one another also influences the interpretation of the traumatic event.

Exactly how lives are "influenced" after a traumatic incident remains uncertain. Literature is not conclusive as to what happens to victims after the experience of crime-related trauma. Some reports by victims after experiencing violent crime do not fit into any of the categories of criteria for post-traumatic stress disorder (PTSD) contained in the Diagnostic and Statistical Manual for Mental Disorders (DSM). McCann *et al* (1988:539) acknowledge that only some of the response patterns of post-traumatic stress disorder are associated with victimisation, "not everyone who experiences violent crime develops post-traumatic stress".

So then, "the present knowledge of post-traumatic stress after more than a decade of application of the Diagnostic Manual, is still found wanting. The Manual has not sufficiently considered the least studied and understood aspect of traumatic stress: secondary traumatic stress" (Figley in Stamm 1995:9-10). It has become necessary to recognise that the process of "*hearing* emotionally shocking material" (O'Halloran and Linton 2000:355) may be traumatic in itself. Like direct trauma, being exposed as a secondary victim (indirectly) can also give rise to acute stress symptoms, depression, anxiety, a sense of violated trust, shattered assumptions, a sense of vulnerability, severed connections to family members and a sense of meaninglessness resulting in a sense of loss.

The present study examines this premise by probing the loved one's experience of the trauma and the many and varied consequences in terms of the emotional heartache, cognitive distortions and relationship changes that result from knowledge of a traumatic event.

1.4 STATEMENT OF THE RESEARCH PROBLEM

The dramatic increase in violence and the radical and flagrant violations of people's personal integrity in terms of callous acts perpetrated against them, have led to various studies aimed at gaining an understanding of the consequences of trauma for *primary victims*. The point of departure of the present study is to examine how these gross insults to people's personal integrity have affected the people *closest to the victims (i.e. the secondary victims - the life-partners)*.

1.5 CASE STUDY

Amy was an entrepreneur, athlete and coach. This energetic 33 year old had provincial sports colours and had always shown a clean medical record. In her work environment she had been promoted to the second highest position in her company after 5 years and had represented South Africa in a professional development programme overseas. Amy had presented with no difficulties in her functioning at work.

She was working toward a post-graduate degree in Business. At home she had a healthy relationship with her husband, Jon, to whom she had been married for seven years. Suddenly things changed - it was in January when she received news that Jon was involved in a carhijacking and had been shot. The doctors reported that it might be difficult for him to ever play sport again, and that the use of his arm might be limited, possibly affecting his current work situation and income. The medical bills amounted to R17 000.

Three months later Amy experienced headaches, pains in the chest and abdomen and a tingling sensation in her right arm, with a numb sensation above her lip. The doctor sent her for blood tests and x-rays but could find nothing medically wrong. The physical symptoms continued. Psychologically she began to feel paranoid. Amy stopped playing sport. She was finding it difficult to focus on or to complete tasks at work, feeling overwhelmed and restless most of the time. She had stopped her studies, preferring to spend time with her family and friends. Amy was sent to a physician who found a slight medical problem (which had possibly been there since birth). However the given diagnosis could still not account for the symptoms she was experiencing. When the symptoms persisted she consulted a psychologist. The diagnosis - secondary traumatic stress presenting as panic attacks after a loved one was involved in a violent traumatic incident.

The case study is a useful illustration of the need to understand secondary trauma. The issues presented form the background to the research topic and are reflective of the question posed in the problem statement.

What are the traumatic effects of violent crime on the secondary victim?

1.6 THE AIMS OF THE INVESTIGATION

The aims of this dissertation are both general and specific.

1.6.1 General aim

The general aim of the study is to gain sufficient background knowledge of the effects on the primary victim of experiencing a crime-related traumatic incident. This will provide a conception of the effects of trauma on the partner, since the phenomenon of trauma appears to be infectious. This general research aim was driven by three considerations.

Firstly, compared to rape, less is known about the psychological effects of other serious crimes, yet carhijacking and armed robbery affect South Africans on a daily basis (Davis, Taylor & Lurigio 1996:22).

Secondly, although some investigators have suggested that family members are affected, factual evidence of the effect on the partner appears to be non-existent. American writers who look at war disasters provide a great deal of the literature on trauma, but little is written about the everyday occurrence of crime-related trauma as experienced by the average South African.

Thirdly, to provide the first South African study on the effects of trauma after violent crime on the secondary victim as partner.

1.6.2 Specific aims

The specific aims of the study are to show the following:

- To determine how the loved ones' cognitive, emotional and interpersonal relations are affected, and what happens to them in terms of acute stress, trauma, loss, depression and vulnerability.

- Primary and secondary victims experience similar trauma patterns as a reaction to a violent incident, but that men do not experience the trauma to the same degree of intensity as women.
- Consequently although they will react in a similar way, there will be a difference in the extent to which each of the parties is affected.
- Victims of crime would experience post/acute-traumatic stress, trauma, loss and vulnerability symptoms.
- Age will be a significant predictor of the magnitude of trauma.
- A greater number of anxiety symptoms will be experienced by women.
- Derealisation will increase according to the severity of the event.
- Dependent and independent variables are correlated.

1.6.3 The broad goal of the study

The main goal of this study is to provide an analysis of the cognitive, emotional and relational effects of violent trauma on the secondary victim (the partner), to broaden the understanding of the patterns of trauma suffered by the partner and to establish what other factors affect victims of crime-related traumatic events.

With these aims and goal in mind this study focuses on:

i) the definitions, severity and history of psychological trauma
ii) the elucidation of the emotional, cognitive and relational symptoms exhibited after trauma, whilst also considering the diagnosis of post-traumatic stress disorder/acute-stress disorder or secondary traumatic stress
iii) designing an appropriate research method
iv) providing measured research findings on levels of trauma, vulnerability, loss, acute stress and depression through qualitative and quantitative methods
v) comparing the difference between primary and secondary victims' experience of trauma

1.7 METHOD OF RESEARCH

The research paper comprises a literature study and a combined qualitative and quantitative study on the secondary victim. The research started from the perspective and actions (Alvesson & Skoldberg 2000:4) of the primary subjects. It is evident that, if no research exists, then one must start with what expertise one has - in this case the primary victim studies.

1.7.1 Literature study

The study of the available literature focuses on the nature of trauma, the history, severity and types of trauma, the meaning of trauma, secondary trauma as the name given to the type of trauma experienced by the secondary victim, criminal victimisation and violence as a precursor to trauma, it explores the cognitive, emotional and relational effects of crime-induced trauma, post-traumatic stress disorder or acute stress disorder (experienced by the primary victim), and secondary traumatic stress disorder (experienced by the secondary victim).

1.7.2 Research study

Quantitative methods comprising three standardised questionnaires were used as operational measuring instruments to determine the impact of trauma on those indirectly traumatised through exposure to the primary victim. On the basis of the findings of this study a description of the effects of experiencing a traumatic incident was formulated for primary and secondary victims as listed below.

The following three questionnaires were given to both primary (victim) and secondary (partner) victims:

1. Schillace Scales
2. Beck Depression Inventory,
3. Stanford Acute Stress Reaction Questionnaire.

The questionnaires measure the following:

- Loss
- Vulnerability
- Trauma
- Depression
- Acute stress reactions, namely:
- Dissociation (including numbing, derealisation, depersonalisation)
- Arousal/anxiety
- Intrusion
- Avoidance
- Impairment in functioning

The 186 answered questionnaires served as a guide for the qualitative research in the form of informal telephonic interviews, some of which resulted in debriefing sessions and observations with the sample group. This provided more depth to the study.

1.8 DEMARCATION OF THE RESEARCH

The approach was practical, where N=186 subjects (93 couples) were chosen on a non-probability or convenience sampling basis. These respondents had experienced crime-related trauma. The representative sample included 85 male victims and 101 female victims, from three different race groups (namely Asian, Black and White). The group ranged between the ages of 18 and 50+years. Adults were studied in terms of the consequences of their experience. How they respond will have an effect on their relationship with their respective partners.

1.8.1 Hypotheses

It is hypothesised, in this study, that primary and secondary victims experience similar trauma patterns after exposure to a crime-related violent incident, but that men do not experience the trauma to the same degree of intensity as women.

Gender-related differences will be found as regards derealisation and perception of the severity of the event. There will be a difference between the way different age groups react to the traumatic event, with those in middle adulthood experiencing the highest degree of trauma. The oldest age group will experience the lowest levels of trauma.

1.9 CLARIFICATION OF KEY CONCEPTS

Defining concepts helps to give precision to the study as it is an analytical tool (Mouton & Marais 1993:158).

Robbery: "Consists in theft of property by unlawfully and intentionally using:

a) violence to take the property from somebody else; or

b) threats of violence to induce the possessor of the property to submit to the taking of the property. It is customary to describe the crime briefly as 'theft by violence'. Such a description reflects the essence of the crime. It is the unlawful, intentional, and violent removing of one's possessions without permission" (Snyman 2002:506). Robbery means that the owner did not consent to the removal of his/her property.

NOTE: In this study the term "robbery" will refer to both carhijacking and armed robbery.

- **Carhijacking:** A car is taken by force or violence from the driver. Life is often threatened and the act may be accompanied by verbal or physical assault.

- **Criminal traumatisation:** "Fear of crime is itself a form of indirect traumatisation, resulting in psychological discomfort, reduced freedom of movement, recreation, sociability and diminished faith in stability in the social order" (Ditton & Farrall 2000:97). When people hear about a carhijacking or armed robbery, it sends out "shock waves" that spread across the community, leading to crime-induced trauma .

- **Direct crime-induced traumatisation** occurs when a victim experiences the act of crime at first hand, resulting in the discomfort mentioned above. This can result in a change in behaviour on the part of the victim.

- **Culture of violence:** A society that endorses and accepts violence as an acceptable and legitimate means to resolve problems and achieve goals (Hamber 2000:5).

- **Educational psychological perspective:** A discipline drawing from the fields of both psychology and education. This perspective is concerned with theories and problems in education and pertaining to that which is mental in origin. A mental view is a particular point of view, or way of seeing something or a situation.

- **Effects**: To have an impact on something. In this context, it would be the intensity of the impact on the victims after a crime-related traumatic experience.

- **Loved ones:** For the purposes of this dissertation "loved ones" will refer to the members of the nuclear family (specifically the partner), who were not directly involved in the traumatic incident.

- **Partner:** Will be the term used to refer to the spouse, intended spouse or the person living with the primary victim.

- **Primary victim:** Refers to the person who experiences the trauma at first hand.

- **Secondary victim/the "hidden victim":** Refers to the person who was not directly involved in the incident, and who did not witness the event. In particular, this person is the spouse or partner of the primary victim in this study. There is an interplay between variables that can predispose a person to trauma through psychological processes of empathy, sympathy and identification.

- **Secondary trauma:** Refers to that which is "experienced or realised through imaginative or sympathetic participation in the experience of another" (Aronson 1997:259).

The secondary trauma refers to emotional upsets experienced by persons who come into close contact with a trauma victim, which may contribute over time to their becoming indirect victims of the trauma themselves (Huber 1994:143).

- **Traumatic event:** Although it is not all unusual for people to experience many intensely upsetting and stressful situations during the course of their lives, only a small number of these would be considered traumatic events. A traumatic event normally causes a stable and healthy person to experience unusually strong emotional or psychological distress which has the potential to interfere with the person's ability to function either at the time of the event or later (McManus 1991:28). Traumatic incidents have subjective effects that vary from one person to another. Usually, an event would be considered traumatic if,

  > *"a person had experienced or had been a witness to an event that involved an actual or threatened death or serious injury.... This threat could have been so overwhelming that the person would have experienced intense fear"* (Herbert *et al* 1999:5) *at some point during the event.*

In the case study (Section1.5) both Amy and Jon experienced an event that could be categorised as traumatic. Jon was carhijacked, which could potentially have led to death and/or serious injury. Amy's response was one of intense fear (upon realising that Jon had been shot) and helplessness that neither she nor Jon could have prevented the incident.

- **Victimisation:** The term "inherently implies a power relationship in which one party dominates another" (McMillan 2001:12) by inflicting exceptional suffering on the person concerned that could be both physical and emotional in nature. It is measurable by the extent to which the aggressor's behaviour needs to alter to ensure that a feeling of safety is restored to the suffering party. This implies that events involving victimisation shape the behaviours of those who experience them (Ditton *et al* 2000:509).

- **Violence:** Violence is the use of physical force or intimidation, which causes physical or psychosocial hurt to another person (Ramsden 1994:7).

- **Vulnerability:** A belief that one is susceptible to future negative outcomes and that one is unprotected from danger and misfortune (Perloff 1983 in Ditton *et al* 2000:100).

1.10 STRUCTURE OF THE RESEARCH PROGRAMME

The intention of the research was to provide a useful basis of current knowledge in the field of trauma. The research programme consists of the following chapters:

- **Chapter 1: Orientation**

Chapter one provides the foundation for the rest of the dissertation. It is essential that any discussion on South Africa be situated within the broader social, historical and political context. However, it is beyond the scope of this dissertation to discuss comprehensively the history and socio-political dynamics of South Africa. Therefore the aim is to provide a broad overview of the context out of which the present study of victimisation of persons emerges, to assist with this statistics are provided. It shows a lack of theory on the effects of experiencing a traumatic incident in the form of carhijacking or armed robbery, for the partner as a victim who experiences secondary trauma. A study of this nature has not yet been done in South Africa according to the researcher's investigation.

- **Chapter 2: Literature review**

Chapter two provides a literature study, which gives insight into the history of trauma theories, and into the severity and types of trauma and violence. It begins with a description of the broad spectrum of trauma and crime-related violence in primary and secondary victims. The researcher attempts to impress that trauma affects the victim's cognitive, emotional and interpersonal functioning. A part of the chapter is devoted to pathologies caused by trauma and to the role of the educational psychologist.

- **Chapter 3: Research design**

Chapter three deals with methods employed for qualitative and quantitative research into the effects of carhijacking and robbery. It also contains an investigation of case studies with reference to completed questionnaires, observations and informal telephonic interviews and debriefing sessions. Response patterns will be analysed and cognitive effects, emotional

effects as well as inter-personal and intra-personal relations will be explored in order to understand how the loved one's general functioning is affected. The researcher will explain which research methods were used in the investigation and how the research analysis was approached.

- **Chapter 4: Discussion of findings**

Chapter four covers the researcher's findings. The reactions of the secondary victim in terms of trauma, loss, vulnerability, depression and acute stress are compared to those of the primary victim after the experience of a traumatic incident. The results and findings of the questionnaires, informal telephonic interviews, debriefing sessions and observations are investigated and tabulated. Some data are interpreted qualitatively. Results of data are statistically analysed, tabulated and graphically presented in the following order: chi square and trend test results from frequency tables, paired-difference t-test and Wilcoxon signed rank test results and analyses of variance and linear regression analyses.

- **Chapter 5: Summary, limitations and conclusions of study**

In chapter 5, the researcher draws together the main conclusions of this dissertation and discusses the limitations of this study, presents summarised findings of the research, and makes recommendations for future research in this field.

1.11 SUMMARY

This chapter has shown that violent crime is a growing problem in South Africa and that after the experience of such an incident, the victims *and their partner* may be traumatised to a similar extent. The uncertainty of the effect of crime on the partner lies in the fact that although there has been research on the effects of trauma on primary victims, no research has been completed on the secondary victim as partner. This chapter has consequently shown the need to examine the effects of violent crime on the secondary victim, namely the **closest supporter (the partner)** of the primary victim.

Insight gained by this means may assist in the development of a therapeutic programme that will pay due attention to the "hidden victim". How the secondary victim responds to the primary victim's experience of personal violence in South Africa may provide some input toward Figley's request for research to provide clinicians with insight into the effects of trauma on those who "care for" (secondary victim) the primary victim. Such insight may lead to a better understanding of the unsolved puzzle of secondary trauma. A case study is cited to initiate awareness on the hidden effects on this victim. To guide the present study further, the aims, hypotheses and research methods, as well as the qualitative and quantitative analyses were described. A brief outline of the structure of the dissertation was also given.

Chapter two begins this process by taking a look at the literature and relevant research concerning the phenomenon of crime-induced psychological/emotional trauma.

CHAPTER TWO
LITERATURE SURVEY

2.1 INTRODUCTION

As our knowledge of traumatic stress grows, so too does our awareness of the high cost of caring. This chapter begins with the assumption that caring for people who have experienced highly stressful events puts the caregiver at risk of developing trauma symptoms as evidenced in the case study in section 1.5.

Emmett *et al* (2000:326) emphasises that "it is not only necessary to address the causes of crime (as presented in chapter one), but also its effects", since before healing can occur a victim needs to understand the reactions induced by trauma and the experience of being personally violated when attacked particularly within the South African context (Greenberg & Ruback (1992:3).

The focus of chapter two, therefore, will specifically refer to the disturbing and frequently overwhelming feelings and symptoms that occur in the aftermath of a terrible event, for both primary and secondary victims. This chapter will therefore provide an understanding of the meaning, history, severity and types of psychological trauma, as experienced in cases of criminal violence. In particular, post-traumatic stress disorder (PTSD), acute stress disorder (ASD) and secondary traumatic stress (STS) will be considered. The concept of systems theory will be introduced. The role of the educational psychologist will be addressed. Most of this chapter will revolve around a discussion on the cognitive, emotional and relational effects of a "traumatic event".

2.2 WHAT IS MEANT BY "TRAUMA"?

"The most intriguing construct to evolve in mental health in the last decade is *trauma and its effects*. The subject of trauma in research provokes such intense controversy that at times it seems to be an anathema" (Hyer 1994:1). The researcher suggests that the reason behind the controversy may be that some of the effects resulting from trauma are so vague that understanding them is living proof of the popular tale about the six blind men describing the elephant, each from a different perspective. This is also indicative of a systemic viewpoint where there are many "realities", perspectives or viewpoints of the various members of the system. The family, considered as a system, consists of members related to the identified victim with the result that they may be traumatised as part of the system.

The researcher will reflect on some of these differing perspectives by offering some understanding concerning the history and meaning of the concept "trauma". The definition of the event and its interpretation are left to the individual and may vary from the death of someone to losing something of importance. Trauma in this dissertation will refer to a kind of "psychological wound" that causes the victim to feel out of control, powerless and helpless. It refers to the "shattering of the person" (Hyer 1994:111) and a wounding of the "self" in the sense of competence and mastery (Reber 1985:789). This trauma is violently produced and is an emotional experience or shock which has a lasting psychic effect (Collins dictionary :1602).

After reviewing countless references from various databases it has become apparent that there is no consistently used term to designate exposure to another's trauma by virtue of the role of loved one and helper. The following three terms are most commonly used: "vicarious traumatisation", "secondary traumatic stress" and "indirect trauma". Field-specific literature on secondary victims emerged in the 1980s in relation to emergency workers. McCann and Pearlman (1990:133) called the stress of working with trauma victims "vicarious traumatisation". Figley (in Stamm 1996:8) stated that "secondary traumatic stress" and "compassion fatigue" applies to supporters of those who experience post-traumatic stress disorder. "Indirect trauma" is the name listed by Pearlman (Stamm 1997:1). Thus, even with the increase in literature there is no uniform designator, nor meaningful taxonomy for the multiple words. Therefore all three terms can be used interchangeably. This study chooses

"secondary trauma" as the term used to describe the effects of a traumatic incident on the partner. It is necessary at this point briefly to explain primary traumatisation and secondary traumatisation:

2.2.1 Primary traumatisation

The primary victim, for the purposes of this research, refers to the person who experiences the traumatic incident of a carhijacking or armed robbery at first hand.

Violence as a precursor of trauma not only has a direct effect on the victim (like Jon in the case study), but also an indirect effect on those closely associated with the victim (Amy in the case study). Research calls this secondary traumatisation.

2.2.2 Secondary traumatisation

This trauma results from knowledge of and hearing about the traumatic experience and not the actual witnessing of the event. Although secondary trauma can have a significant affect on all who care for and are around the primary victim, it predominantly impacts on the closest supporter, namely the partner, according to this study's assertion.

Pearlman (in Kleespies 1998:252) defines secondary traumatisation as a process of change, a natural by-product of engagement with trauma victims in a caring and empathic way. This trauma derives from awareness of another's misfortune, and necessarily involves the process of identified association with the victim after a traumatic event (Aronson 1997:263). In particular, says Figley (in Friedman 1996:37), the partner is at risk of becoming susceptible to being traumatised through this process.

2.3 SEVERITY AND TYPES OF TRAUMATIC EVENTS

Traumatic events can be divided into three types of categories:

a) Man-made disasters

b) Natural disasters

c) Acts of violence, crime and terrorism

Literature (Allen 1995:6) find that out of the three mentioned disasters traumatic events like criminal violence, which are deliberately inflicted by human agency with malicious intent, are associated with longer-lasting psychological distress than trauma generated by natural disasters (e.g. earthquakes) or man-made (but non-deliberate) disasters (e.g. car accidents). It may be that violence-induced trauma is worse than natural and man-made (non-deliberate) disasters because the trauma that results from the event could in fact have been prevented as Hume and Wynchank (2000:50) state "when suffering is meaningless it is much harder to bear".

In understanding the severity of trauma due to criminal violence inflicted on the victim and his/her closest associate, it is necessary to see where trauma as a theory originated and how it is perceived at present in South Africa. "The history of trauma theories provides some understanding of trauma and violence" (Hyer 1994:14) and will be outlined briefly.

2.4 THE THINKING ABOUT "TRAUMA"

2.4.1 A historical overview

"Trauma", "stress" or "stress disorders" have been described as problems people have experienced throughout time. Hetz (1999:11) records that one of the most significant earlier contributions came from Jean-Martin Charcot, who in the 1800s introduced the concept of traumatic hysteria as the emotional effect of exposure to a shocking event. Building on this work Pierre Janet (1889) and Charcot offered the first explanation for trauma as psychological disassociation which occurred following shock (Kaplan & Sadock 1994:644).

Trauma was first understood by psychologists as a psychological breakdown caused by external events that exceeded the capacity of the psychological structure to respond to overwhelmingly shocking events, as reflected by Freud in his psychoanalytic reflections. Trauma for Freud was the core of subsequent psychopathology such as obsessive-compulsive neurosis and hysteria. Hysterics, Freud noted, "repress the memory of certain very intense or painful experiences", and numb feelings associated with the event (Garland 1998:13). The feelings then become visible via "hysterical symptoms". Furthermore, Freud believed that the obsessional preoccupations of the traumatised person might be an attempt to process the

intense emotions surrounding the painful experience. The person is often caught up in the painful event of the past instead of seeing it from the present (Garland 1998:13). As a result of this, Freud maintained that the "ego's defence is depleted and overwhelmed". The importance of defences is that they protect the person against the annihilating blow of trauma. Trauma can cause these defence mechanisms to break down, leaving the person exposed and vulnerable. Wilson and Krabs (Peterson, Prout & Schwartz 1993:88) suggested that a resulting consequence of the depleted ego after trauma was that the ego may undergo regression to earlier modes of adaptation; a change in hierarchy of needs or the experiencing of a conflict of that developmental stage.

Williams (1980 in Peterson *et al* 1993:82) criticised the work of psychoanalysts, such as Freud, for treating the nature of the event as irrelevant and rather focusing on individual weaknesses as being the cause of post-traumatic stress disorder instead of the nature and extent of the stressor. However, Hendin (Peterson *et al* 1993:82) contradicts this criticism of Williams by suggesting that it is exactly this focus on the psyche of the individual which makes the contribution of psychoanalysis so vital, as it provides a greater understanding of the reaction of the individual to traumatic stress. Hence the contribution of psychoanalysis to trauma work lies in its suggestion that it is not the event itself that causes the traumatic stress, but the mind (psyche) of the individual.

The occurrence of the World Wars led to a changed understanding of and renewed interest in traumatic stress and the impact of war on soldiers. Post-traumatic stress was only diagnosed for the first time in 1980. So one might ask if this diagnosis dates from 1980, "is post-traumatic stress disorder a sign of our turbulent times" (Hume 2000:50)?

Although post-traumatic stress disorder was diagnosed recently, it is not a new condition. Throughout history, it has been described in a number of different ways. The condition became known as gross stress reaction, which was then designated as post-traumatic stress disorder for the first time in the first Diagnostic and Statistical Manual of Mental Disorders (1952). No specific symptoms were described and the reaction was considered reversible.

During the American civil war (1816), "soldier's heart" caused massive disability. The same condition was called "shell shock" during the First World War (1914-1918) and "battle

fatigue" during the Second World War (1939-1945).

The Vietnam War (1964-1975) led to the first systematic study of the traumatic response syndrome. Vietnam (or 'Nam) was a seemingly pointless war in another land. The soldiers who returned were therefore not celebrated as heroes. This lack of endorsement made their suffering worse. In 1980, traumatic response syndromes were recognised as a component of injuries, muggings or witnessing violent acts (Miller 1994:655). In 1994 these syndromes were included in the Diagnostic and Statistical Manual of Mental Disorders (1994:424) for the first time.

2.4.2 Violence as a precursor to trauma

During the 1990s violence in some form was an everyday experience for many people around the world. As a result a more scientific study of the *effect of trauma* on psychic functioning and symptom formation occurred. Becker wrote that (http://www.berghof-centre.org/handbook/becker/s2htm) "what characterised trauma most was its inescapability, its uncertain duration and potentiality for loss of one's own life. Nothing was predictable and therefore nothing could be done about it". He was the first to recognise that trauma could not be categorised in the usual psychiatric language. The words *"extreme traumatisation"* came to be recognised where post-traumatic stress disorder did not apply. In this extreme form the condition, is characterised by a structure of power which spreads from person to person within societies and communities." Garland (1998:13) describes the experience of extreme trauma as follows:

> *"The experience of the extreme traumatic incident (such as carhijacking or robbery), leads to a massive disruption in functioning leading to a breakdown. This breakdown occurs in the way one goes about life, established beliefs and predictability of the world. It leaves the person vulnerable to intense and overwhelming anxieties from internal events and external sources, creating defence mechanisms, where fears, impulses and anxieties are all given fresh life, thereby shattering their world. There is a rapid return to primitive paranoid beliefs about one's status in the world. Confirming the worst of the internal fears and fantasies, including the reality of death and personal annihilation. There is a collapse in meaning of life. "*

In the understanding of the history of trauma and extreme traumatisation due to violence one should acknowledge two basic difficulties. On the one hand, the intra-psychic processes are considered, while on the other, society must be considered. For example, the severity of the

traumatic event is played down by society with statements like "You are so lucky to be alive". This may be society's attempt to minimise the impact of crime for itself, but it is done at the expense of an awareness of the psychic processes involved in trauma.

It is necessary at this point to bring the study of trauma into focus with respect to South Africa. Cases of criminal violence perpetrated by members of society against fellow citizens have long been a prominent feature of South Africa's social and political environment (Niehaus,Van Niekerk & Stein 1998:103). Farber-fischer (1997:3) and Holford and Smith (1993:58), speaking from their experience with South African clients, have drawn similar conclusions about the present situation in South Africa. Farber-fischer says, "South Africa is in a state of continuous stress disorder (a form of extreme trauma). These people live in current, repetitive and unrelenting traumatic surroundings. Even post-traumatic stress disorder is a misnomer in the South African context because of the continuous traumatic stress often present in many cases". This statement suggests that stress levels in South Africa re so high that is its difficult to distinguish post-traumatic stress disorder victims from a random sample of members of the public due to the continuous stress disorder situation in South Africa. An understanding of the criminal violence in South Africa may shed some light on comments such as these.

2.5 THE TRAUMA OF CRIMINAL VIOLENCE WITHIN SOUTH AFRICA

There are different kinds of violence. It is important to be clear about these differences as violence is often taken to be a single, general problem in society. It is not. As long as South Africans think of it in this way they will fail to deal effectively with both the reasons that lie behind the various kinds of violence and the consequences. Perhaps the main distinctions that need to be drawn are between political violence, gang violence, general criminal violence and violence in relationships. Although there is some overlap there are also some important differences. While acknowledging the importance of understanding all types of violence, this research will focus only on criminal violence because in South Africa today other forms of violence are overshadowed by criminal violence (Hamber 2000:7).

Although gangs are often involved in criminal violence, random criminal violence may take place through a group, it is not necessarily organised or driven by gangs. Increases in this

kind of violence is causing concern at many levels of South African society and are of deep social concern (McKendrick *et al* 1990:203). Not many social occasions go by in South Africa without the conversation turning to violence and crime. When it comes to violent crime South Africa is in a class of its own (refer to the statistics in section 1.2.2.1). "The trauma situation is disastrous. It is way beyond that experienced internationally: death by non-natural causes is three times more common in South Africa than globally" (Van der Spuy 1996:34).

Moreover survey data suggest that fear of crime is increasing, that feelings of safety and security are diminishing, and that crime is now considered the most pressing problem facing people of all races in South Africa. Probably most disconcerting is that, for many people, the fear of losing one's life now overshadows all other fears associated with criminal violence (Louw 1997:138). It is due to this overriding fear that it becomes necessary to explain and to measure through research what effects criminal violence has on the victims in society.

Criminal victimisation leaves the victim *and his/her partner* feeling singled out for harm. Victims lose personal possessions and their sense of personal safety. Personal possessions are symbolic expressions of the self. Some form of personal violation has occurred. Thus a threat to these possessions is a violation of and intrusion into the self (Reid 1997:7). Such violations of one human being by another highlight the predatory side of human nature (McMillan 2001:12) and gives rise to feelings of isolation, confusion and stress. It destroys people's sense of trust and control over the world, leaving them feeling that they are vulnerable and that their world is unpredictable. The researchers Miller (1999:22), Schultz, Van Wyk and Jones (2000:137) and McMillan (2001:14) add that besides having an influence on relationships between persons and groups, trauma as a result of violent crime can also affect every aspect of human existence to varying degrees. They state that trauma can undermine development, self-esteem, relational stability and confidence in all spheres, from educational achievement through adulthood thus constraining achievement of the victim's full potential.

Wertz (1985:197) states that in order to function, people need to see their world as predictable and themselves as relatively invulnerable. In the context of crime-related trauma the physiological and psychological impact follows from a situation in which the victim

experiences a state of helplessness in the face of a force which is perceived as life threatening and overpowering, and such that neither resistance (fight) nor escape (flight) is possible, as the victim is left at the mercy of the perpetrator. This flight or fight response is a natural human strategy for survival in a traumatic or stressful situation. When one's natural strategies fail it leaves one feeling extremely vulnerable. It follows then, that if Wertz is correct, people who experience carhijacking should be unable to function. Chapter 4 will comment on the present research findings on how people in South Africa function after criminal victimisation.

Victims of trauma experience stress responses to various degrees, sometimes lasting for months or years after the incident took place. In fact the full clinical picture after the experience of crime-related trauma shows significant distress in social, occupational and other important areas of functioning in the primary victim.

2.6 THE EFFECTS OF TRAUMA ON THE PRIMARY VICTIM

It is the effect of trauma on the primary victim that evokes the response in the secondary victim - the victim that forms the focus of this research. It seems important that before one can understand the reactions of secondary victims, it is necessary to understand the response of the primary victim. In agreement with this is the view expressed in Herbert *et al* (1999:33) that an understanding of the "emotional scarring" that the trauma survivor bears will "lessen the destructive impact of the ripple effect that crime can have on relationships". A case in point comes from the researchers Roe-Burning, Straker (1997:323) and Gabriel (2001 http://www.naswync.org/p30.html) who believe that *simply listening* to the account of another's trauma may "shatter the assumptions" that the secondary victims hold about their identity as a partner, and their own view of the world after trauma.

According to Janoff-Bulman (Greenberg *et al* 1992:3) when trauma occurs, one or more of the following three inner beliefs are destroyed and a search for meaning takes place:

- Belief in a compassionate, meaningful and comprehensible world
- Belief in personal invulnerability
- A positive sense of self-worth

"This devastation may be due to the two often emerging stages of development in the

survivor: there is the initial disruption of normal mental functioning, which follows the breaking of the protective shield, that is to say, the mind's normal capacity to filter out excessive or painful stimuli" (Freud in Garland 1998:112). The survivor of a crime-related traumatic experience is shocked and confused, perhaps unable to take in what has happened. S/he may become silent and withdrawn, or compulsively talkative and active, but in either case, his/her normal functioning is in a state of disintegration and s/he is unable to think or behave in a rational manner.

The second stage is when the victim appears to the outside world to be fine. However, internally the picture is different. This longer-term internal situation is the result of two powerful drives:

- First is the way in which, from infancy, the victim has attached his/her experience to something felt to be responsible for the perception, feeling or sentiment experienced. As a result the survivor may feel plagued by bewilderment, discouragement and a sense of persecution.

- Second in the effort to give a traumatic experience meaning, the person links it with what is already familiar. A trauma in the present will link up with trauma in the past and give it new life. So then, it is possible for some suppressed trauma or emotion to surface at a time when it is not expected or remotely related to the event, intensifying the incident.

Along with this drive to make sense of the robbery for example a syndrome of symptoms may present as post-traumatic stress disorder.

2.6.1 Post-traumatic stress disorder in the primary victim

Post-traumatic stress disorder is the term given to a particular range and combination of reactions following a trauma. **It is the most extensively documented affective disorder experienced after trauma.** Kaplan and Sadock (1998:618) define post-traumatic stress disorder as a set of symptoms that develop after a person sees, is involved in, *or hears of an extreme traumatic stressor*, as classified in the DSM-IV-TR (2000:467). Fear and

helplessness, persistent re-living of the traumatic event, and avoidance of reminders of the event, constitute the person's reaction to the trauma. Violent crime is included in the DSM-IV as a traumatic stressor capable of precipitating the full pattern of post-traumatic stress disorder symptoms in both primary and secondary victims. The reaction of post-traumatic stress disorder is overwhelming enough to affect most people. The primary victim avoids anything that could bring the event to mind and undergoes a numbing in responsiveness along with a state of hyper-arousal (DSM-IV-TR 2000:468).

The DSM-IV criteria for post-traumatic stress disorder have been criticised for being too restrictive as the diagnosis is biased toward those showing re-experiencing rather than denial symptoms. Only persons who demonstrate both re-experiencing and denial symptoms are likely to receive the diagnosis (Laufer in McCann *et al* 1988:537). In addition, uncertainty arises in that the DSM-IV criteria do not reveal any specification of the natural course of post-traumatic stress disorder, as well as the necessary frequency and duration of symptoms in order to accurately diagnose this disorder. An implicit assumption is that post-traumatic stress disorder arising from whatever cause is essentially the same, in the sense that there are established symptoms and criteria for diagnosis. However the nature of crime-related trauma sequelae could differ to the extent that grouping together those meeting the diagnostic criteria is questionable (Rothstein 1986:223). Therefore the victim experiences a lot more than can be explained as post-traumatic stress disorder, much of which has not yet been examined or explained, in relation to crime. Kamphuis and Emmelkamp (1998:200) agree with the researcher and caution that studies with regard to post-traumatic stress disorder have focused on war and disaster, and not specifically on post-traumatic stress disorder caused by violent crime.

The explanation of post-traumatic stress disorder offers a reasonable explanation as to why this disorder can be so pernicious and debilitating for some victims. Still, Epstein proposed that post-traumatic stress disorder has a positive value in that the victim is constantly seeking a resolution or meaning in this turmoil (Hyer 1994:139). Symptoms of post-traumatic stress disorder are categorised under the headings of cognitive, emotional and relational effects.

For the purposes of this research it is not possible to discuss all of the effects in detail. Those in italics are the symptoms measured quantitatively (by the standardised questionnaires) in chapter four and are therefore reviewed through literature. Other symptoms of post-traumatic

stress disorder are mentioned but are not measured or explained, they are referred to for the sake of completeness.

The following **cognitive (thinking) effects** may be experienced after crime: repeated imagery *(intrusion), avoidance, dissociation,* confusion, disorientation, indecision and memory loss. **Emotional (feeling) effects include:** *anxiety,* fear, *anger (retaliatory needs), depression, arousal,* helplessness, hopelessness and emotional *numbness* (difficulty experiencing feelings, including those of love and intimacy, or taking interest and pleasure in day-to-day activities). Finally the **relational (interpersonal) effects experienced after crime are:** a feeling of *vulnerability,* neediness, dependency, distrust, irritability, conflict, isolation, feeling rejected or abandoned, being distant, being over-controlling in relationships, and experiencing a sense of *'loss* of a sense of self' and self-worth.

Before going on to discuss the cognitive, emotional and relational effects of trauma, this study will pause to consider what is understood by acute-stress disorder. Acute stress disorder's most significant contributing factor to this study is that it can create dissociation as a defence. Dissociation is a necessary variable to this study and is measured in chapter four (Graph 4). The reason for measuring dissociation is the researcher's belief that if the primary victim withdraws consciously or unconsciously (dissociates) from his/her environment and the people around him/her it could be detrimental to his/her relationship with the secondary victim. It was found that in some instances couples affected by trauma had separated after the event. There may be a causal relationship between withdrawal and this fact or it may be a trend in the general population of people in the same age group.

2.6.2 Acute stress disorder

Both acute stress disorder and post-traumatic stress disorder are conditions that can occur in people who have been exposed to a traumatic life event. Acute stress disorder is a variation of post-traumatic stress disorder. What differentiates the two conditions is the point of time at which the symptom is experienced after the event. Acute stress disorder defines the immediate response to trauma for up to four weeks. A table that juxtaposes comparative particulars of acute stress disorder, post-traumatic stress disorder and secondary traumatic stress disorder is provided in *appendix A.* Explanations of the effects (symptoms) that follow

apply to acute stress, post-traumatic stress and secondary stress.

2.7 COGNITIVE EFFECTS

The thoughts behind the Trauma - "To want to forget something is to think of it" (French proverb)

"Three decades have passed since Ellis popularised Rational Emotive Therapy which holds that thinking causes problems in living" (Hyer 1994:215). The cognitive distortions which occur after a traumatic episode are indicative of how "thinking" can create difficulties. People have been equipped with a defence mechanism that "opens" all their senses in crises in order to secure a rapid intake of outer stimuli that can be used when deciding on what to do. These defences help the victim to survive. However the price they pay for this is the intensity to which sensory impressions are imprinted in their memory and cognitions. It is this "memory" that forms the basis for later intrusive thoughts, behaviour and images (Dyregrov 1992:193).

The individuals' core cognitions regarding the meaning of the event will influence later behaviour because it is the victim's interpretation of the event, rather than the given facts, that ultimately determines the reactive behaviour. As Hyer (1994:113) postulates, when trauma is excessive, the person's thinking is intruded upon, often leading to dysfunctional beliefs and actions that mask any understanding of the real "self". Consideration of cognitive beliefs and mental functioning is therefore imperative as trauma survivors rely on the capacity of the mind to manage. A discussion of the subsequent cognitive beliefs (measured in chapter four) follows under the headings of: intrusion (2.7.1), avoidance (2.7.2), and dissociation (2.7.3).

According to Kaplan and Sadock (1994:608) cognitive responses in cases of post-traumatic stress disorder or acute stress disorder include persistent experiencing **(intrusion)** of the event, **avoidance** of stimuli associated with the event and the numbing of general responsiveness **(dissociation)**. Cognitive symptoms include time distortions, self-blame, foreshortened sense of the future, altered goals, as well as immediate changes in attention and hyper-vigilance **(arousal),** which is discussed under emotional effects.

2.7.1 Intrusion (Graph 4)

As Allen (1995:4) puts it, the traumatic event has ended but the reaction has not. The "*intrusion* of the past into the present is one of the main problems confronting persons who have developed psychiatric disorders as a consequence of a traumatic incident". **Intrusion**, as a cognitive response, refers to experiencing the traumatic event in thoughts and through imagery (nightmares, fearful thoughts and flashbacks) that are common among persons who are victimised (McCann *et al* 1990:132) and are characteristic symptoms of a stress disorder.

Flashbacks, as an illustration of intrusion, are memories that are experienced as if the event was taking place all over again. They can occur at any moment and can be extremely disturbing to individuals (and often to his/her partner) because all the physical sensations that were present during the original trauma are experienced yet again. It is quite natural to feel that your mind is being taken over by the past events (Herbert *et al* 1999:19). In other words, the traumatic "pictures" are presented repeatedly as the mind strives to make sense of what has happened.

Rachman (in Rusch, Grunet, Mendelsohn & Smucker 2000:173) proposed that intrusive phenomena cause distress when they are repetitive and unwanted. These phenomena interrupt cognitive processes significantly, incite pessimism and prove difficult to cope with. The perceived inability to stop intrusions may cause victims to question their personal control and mental stability. Not being able to control these cognitions may in turn lead to anxiety and depression (Baum in Rusch *et al* 2000: 175), the most common feelings felt after a traumatic incident. However, if intrusion does occur without feelings, it is thought that numbing or some form of protection against those feelings has occurred due to an overwhelming influx of stimuli. Marmar and Horowitz (in Macgregor 1998:7) suggest that part of the cause for the stress syndrome is a cycle of fluctuations between occurrences of **intrusive imagery and avoidance** of traumatic affect.

2.7.2 Avoidance (Graph 4)

Avoidance behaviour literally means keeping out of the way of any person (this could include the partner), place or object that might be even a remote reminder of the trauma. Avoidance patterns seem unconsciously to minimise, forestall or disrupt the potential eruption of intolerable memories, thoughts and affects (Parson 1998:246). "Avoidance" reactions can manifest themselves in numerous ways. The drive to avoid pain by not talking or thinking about the event, trying to evade further trauma or to make sense of trauma, causes disruption of the processes of thinking and perceptions. Distorted thinking and perceptual disturbances, sometimes as a result of avoidance, are commonly occurring reactions after trauma.

For many trauma victims avoiding conversations with others (such as their partner) results in self-protective negative self-talk. This prevents them taking risks in their environment and thus thwarts opportunities for corrective learning experiences that would change these faulty and sometimes dysfunctional beliefs. Meichenbaum (Hyer1994:311) concurs that poor trauma recovery is often due to negative self-attributions and self-beliefs that foster a repetitive negative self-talk. According to Rusch *et al* (2000:173) avoidance results in negative, distressing thoughts and images that are associated with anxiety and depressive disorders. Both depression and anxiety undermine the idea of a safe, meaningful and essentially good world and send the victim into a tailspin of emotional turmoil, resulting in numbing (a state where a person's capacity to feel emotions is reduced). Numbing may affect the victims' capacity to laugh or to cry. Sometimes even the capacity to love is affected. This is possibly motivated by the desire to prevent any further pain as a result of having *lost control,* and to protect the "wounded self through a very narrow interpretation of what is considered to be 'safe'" (Herbert *et al* 1999:25). The result of avoidance may be counter-productive as the victim may end up isolated from his/her partner. In the extreme form of avoidance **dissociation** occurs as a defence against this emotional mayhem.

2.7.3 Dissociation (Graph 4)

"The term used to refer to a process whereby a person who is experiencing unbearable trauma distances him/herself from it" (Horsman 1999:82). These people detach from the self and/or environment. Dissociation refers to feeling unreal or "outside oneself", as in a dream,

or experiencing "blank" periods that one cannot remember. It refers to states of altered consciousness such as voluntary thought suppression, minimisation and denial. It is any attempt to survive the agonizing reality of human induced trauma. Research shows that dissociation is typically present during or shortly after the traumatic event (Cardinal & Spiegel, 1993; Shavlev *et al* 1996 in Stamm 1996:293). Dissociation results when aspects of the experience are not integrated, but are stored in memory as isolated fragments and saved as sensory perceptions, affective states or behavioural re-enactments.

Research has shown that dissociation is the long-term predictor for the ultimate development of post-traumatic stress disorder (Van der Kolk & Fisler 1995 http://www.trauma-pages.com/vanderk2.htm). One such study done on Vietnam War veterans reported higher levels of dissociation among those who developed post-traumatic stress disorder than among those who did not develop the disorder. "Terrifying experiences (such as carhijacking and armed robbery) that rupture people's sense of predictability and invulnerability can profoundly alter the ways in which people subsequently deal with their emotions" (Meichenbaum 1994 in Hetz 1999:9).

In summary, denial, numbing and **dissociation** represent efforts to **avoid** what has happened, whereas **intrusion** and re-experiencing represent efforts to confront what has happened.

"Trauma evokes a wrenching interdependence" between emotions and cognitions. It follows that one cannot study one without the other (Murphy, Braum, Tillery, Cain, Johnson & Beaton 1999:274).

2.8 EMOTIONAL EFFECTS

The emotional side - "Suffering is the badge of the human race" (Mahatma Ghandi)

"There are no scars and gaping wounds, no broken bones or cries of agony. The pain lies hidden" (Stucky 1998:2), buried under depression, anxiety, anger, dissociation, denial, avoidance, sense of loss and vulnerability. Emotional trauma following an act of crime is debilitating. However since post-traumatic stress disorder seldom reveals any outward signs people carry this burden in silence. Emotional trauma is frequently dismissed. Still, the

untold cost to society of this hidden anguish is immense.

Psychologically, says Allen (1995:14), the bottom line of trauma is overwhelming emotion and a feeling of sheer helplessness. Allen (1995:50) believes that people observe the world, and therefore situations that are harmful, injurious or frightening, in an emotional way. These reactions prompt and prepare the victim to cope. With trauma, emotions can be so intense and prolonged that adaptive signals, such as fear and anxiety (2.8.1), unusual aggression/retaliation (2.8.2), depression (2.8.3) and arousal (2.8.4) which usually allows one to cope may be undermined. People experiencing traumatic events inevitably experience powerful emotional reactions such as these because their normal homeostatic functioning on a physiological level is disturbed. The experience of violence, the researcher suggests, exposes one to a variety of emotional reactions similar to Kubler-Ross (www.psy.pdx.edu/PsiCafe/keyTheorists/KublerRoss.htm) "steps of grieving" namely: denial and isolation, anger, bargaining, depression and acceptance. The final step of acceptance may never be attained due to the possible constant physical reminder of injury, death or financial loss that criminal violence imposes.

Symmonds (1975 in Bisson & Shepherd 1995:718) gives the following four-stage emotional reaction specific to victims of violence.

Stage 1: Initial shock and denial
Stage 2: Fear and anxiety
Stage 3: Apathy and anger ensue, often accompanied by feelings of depression, or the need to retaliate
Stage 4: Resolution

Only Stages 2 and 3 and the experience of arousal will be explored as they are measured through the standardised questionnaires used in this study.

2.8.1 Fear and anxiety (Graph 2)

These are the most frequently experienced emotions and are the most predominant early emotional experiences after denial. Findings provide strong support for the universality of

anxiety and fear reactions across victim groups (De Fazio 1975; Fay *et al* 1984 in Mc Cann 1988:539). The type of fear and anxiety experienced after violent crime has both an

emotional component and a social factor as indicated by Janoff-Bulman (McMillan 2001:12). Her belief about trauma suggests that although one's assumptive world needs to be reorganised, post-traumatic stress is influenced by coping variables like social support. The client with post-traumatic stress disorder, she says, often seeks isolation, and may avoid people (like his/her partner) and activities out of fear of how others would respond when told about the nature of the trauma. In relation to carhijackings people can subtly chastise the victim for taking "dangerous" routes and for "not doing the right thing". In this regard, Marsh and Greenberg (1996:212) refer to Herbert (1992), Schumaker & Brownwell (1984) and Simons (1980) who all believe that victims of crime do not always receive the support they expect from others. They labelled these insensitive and sometimes hostile reactions to crime victims "the second injury". Efforts to account for such reactions centre on the threat that the victimisation poses to others (Marsh *et al* 1996:211). By finding fault with the victim, particularly his/her behaviour, others can maintain their belief in a "just world" and in its controllability, thereby reducing their own anxiety and reassuring themselves that a similar fate does not await them.

A constant state of anxiety can be the outcome of this lack of social support, as the victim becomes increasingly more pensive over his/her actions during the event. Anxiety tells us that something is wrong, but like mist, it is not tangible. This emotion is linked to the unexpected and a loss of control. It signals danger and stress ahead. Anxiety tells the victim to put everything on hold while one figures out what to do next, leaving victims with feelings of defencelessness. Sometimes this sense of helplessness causes the victim to become so introspective that s/he tends to focus inward on his/her own distress (Rosin 1998:8 & Allen 1995:52). Some of this discomfort is in the form of internal sensations and psychosomatic difficulties such as increased heart rate, blood pressure, gastrointestinal disturbances, headaches, fatigue and chest pains or tingling sensations (Mc Cann *et al* 1988:545). Anxiety also signals arousal feelings of agitation, distress, fear reactions including phobias and nightmares, which could be both temporary or long-term (Mc Cann *et al* 1988:540).

While temporary anxiety is adaptive, long-term anxiety leads to the stimulation of events

which can become self-defeating. For example the victims can find themselves not wanting to go out for fear of what might happen again. This in turn can lead to a number of related difficulties such as loss of social support and depression. Two forms of self-defeating behaviour can also occur and include self-mutilation and comfort eating. "For some, just the action of filling themselves with food" (Herbert *et al* 1999:25) or "cutting" themselves can alleviate ambivalent feelings of inner emptiness on the one hand and the extreme turmoil produced by anxiety or anger on the other.

2.8.2 Anger/retaliation (Table 4.6)

Anger is a subjective emotional state induced by extreme displeasure after an unhappy experience. It is not uncommon for people to experience intense anger after being exposed to a violent incident. However, some deny awareness or expression of their own anger. A victims' anger, may be generated by unmanageable anxiety resulting from their exposure to violence. Garland (1998:81) warns that people who are too afraid of their anger may remain crippled by the trauma for a considerable time. One recalls (from chapter one) how counsellors in refugee camps had to coach victims to become angry before self-healing could occur.

Parens (in Allen1995:55) suggests that, underlying irritability or anger tends to lead to violent aggression and hostile destructiveness. These reactions may also result from the victim's loss of illusion about his/her world as being safe, (Janoff-Bulman in Peterson *et al* 1993:79). The victim may perceive the loss to be irreparable and may mourn it forever. Part of the mourning may be attributable to the financial loss and physical injury so often connected with victimisation. Melanie Klein (Garland 1998:99) writes that "any pain (loss) caused by unhappy experiences, whatever their nature, has something in common with mourning," but most devastating is the emotional pain caused by crime, which can lead to depression.

2.8.3 Depression (Graph 5)

Depression literally means "pressed down". Depression, sadness, vulnerability, guilt, shame and helplessness are frequently reported as immediate responses to criminal victimisation (Mc Cann *et al* 1988:541-542). A number of factors are considered psychological triggers for

depression according to Jackson and Bates (1997:77): *intrusive* symptoms (traumatic dreams or imagery of the carhijacking), lack of energy, lack of interest and lack of drive. It is believed that most of these triggers for depression originate because of loss of a previously held image of the ideal world (Allen 1995:63). The victims' clear view of the world shifts after crime-induced trauma. *Depression* ensuing from loss/failure of whatever form seems to encompass all of the expressed emotions so far. Severe stress, *anger, anxiety,* sleep disturbances (including flashbacks), *arousal,* restlessness, excessive vigilance, exaggerated startle response, *numbing* or *avoidance* of reminders of traumatic events may therefore occur (these italicised responses are measured on primary and secondary victims the results of which are presented in chapter 4).

2.8.4 Arousal (Graph 2)

The DSM-IV (1994:428) lists the following symptoms of increased arousal:

- difficulty falling or staying asleep
- feeling overwhelmed by people
- exaggerated startle response to the slightest noise or movement
- irritability
- lack/loss of concentration

Victims of crime often report "insomnia, irritability, restlessness and inability to focus on tasks" as recurring concerns after the event. Indeed, as is true of anxiety, many physiological reactions of arousal are also associated with post-traumatic stress disorder, for example dizziness, rapid heartbeat, various pains, headaches, debility, nausea, difficulty swallowing, breathlessness and perspiration. This physiological state of arousal is part of the body's flight or fight adaptive response. However, crime-related trauma can convert this adaptive response into a pathological state of hyper-arousal. The victim begins to react strongly or emotionally to minor provocations. These victims are also more prone to developing panic attacks – an extreme form of anxiety. To experience such extreme anxiety threatens annihilation of the human personality and personal spirit (Kalsched 1996:1).

In summary, becoming a victim of crime leaves victims *and those around them* in a state where they cannot think clearly and may feel overwhelmed by intense emotion and

unresolved information and issues. In this regard Beck and Freeman (1990:37) state that when depression occurs "the orderly processing of data is systematically bound in a dysfunctional way and not until this insult is rectified will tranquillity return". (Beck is the developer of the depression-measuring inventory – the BDI - used in this study). So it stands to reason that "tranquillity" for a time is lost for the victim because of the cognitive and emotional experiences highlighted so far. In turn, these experiences affect relationships with the self and with others.

2.9 RELATIONAL EFFECTS

Love and suffering are two sides of the same coin! (Aristotle)

Aristotle thought that connection was based on the idea that once a person loves, any *imagined loss* of the other is unbearable. The central question of the study remains, namely to determine the effect of trauma in terms of the inordinate amount of stress imposed on the cognitive and emotional capacities of the victim, whose belief structures have been shattered by the causal incident, and to determine the reactive ramifications for the relationship with his/her partner.

Every person is a fundamental part of the dynamic strands, consisting of intrapersonal and interpersonal relationships, that make up the "self". The strength of these strands influences the image the victim holds of his/her world. When trauma occurs after crime, the "indelible image" of the victim's world, as composed by his/her beliefs, expectations, assumptions and perceptions of self-worth, is undermined (McMillan 2001:12). Various arguments exist as to why criminal victimisation undermines self- worth.

2.9.1 Arguments provided for loss of self-worth due to criminal victimisation

The first is Maslow's popular theory of a hierarchy of needs (illustrated in Figure 2.1). It emphasises that if a person's stability is disrupted by a lack of safety, whether real or perceived, then the realisation of self-worth is also jeopardised.

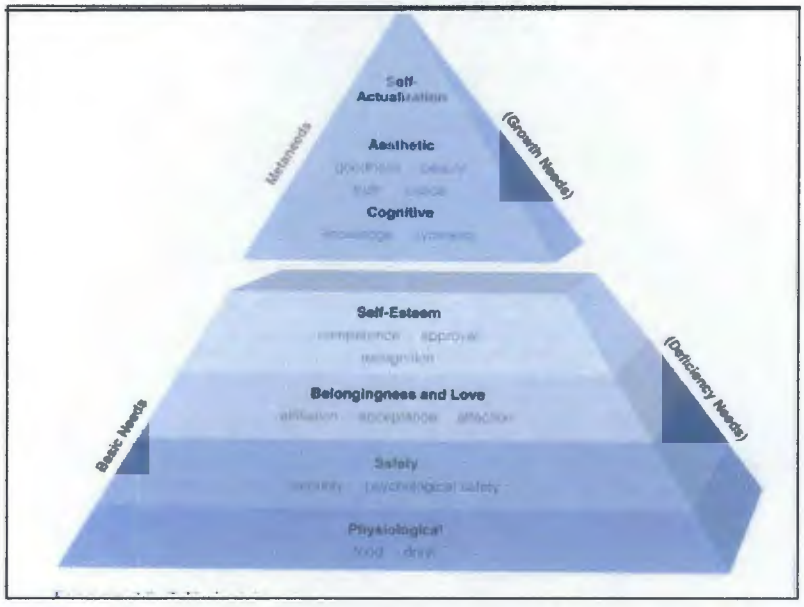


FIGURE 2.1 *Maslow's hierarchy of needs* (Le François 1997 :360)

Literature references will reflect in more detail on two other arguments given for the loss of self-worth. It states that after victimisation, **loss** (of control) and **vulnerability** are the two causes for a change in the victim's image of his/her world and his/her perceptions of "self" ("loss" and "vulnerability" are variables measured in the research study).

The second argument states that *loss* of self-worth stems from the *loss* of control over life events (Bard and Sangrey 1985; Krupnick 1980 in McCann *et al* 1988:547). After a traumatic event like robbery nothing is ever the same again. "This profound loss of the familiar is a hallmark of trauma" (Saakvitne & Pearlman 1996:26). Freud (in Parson 1998:254) wrote that after trauma a person is brought to a stop by an event which shatters the foundation of his/her life. The victim no longer knows what to expect for him/herself. Victims then start to see themselves as weak, vulnerable, and helpless or as deserving of their experience. There is much self-blame and depressed mood (Rothstein 1986:223), which Kilpatrick states (in Mc Cann *et al* 1988:542) are universal responses to victimisation.

The third argument is that the "illusion of *invulnerability" (*Hetz 1999:45) is lost. Janoff-Bulman and her colleagues (1992, in Davis *et al* 1996:24) postulate that people who are victimised can no longer assume that "it cannot happen to me", instead they *know* that "it can happen again" (Janoff-Bulman in Peterson *et al* 1993: 80). This in turn affects the person's sense of safety in the world and a sense of uncertainty becomes a part of life (Janoff-Bulman

& Frieze 1985 in Roe-Burning *et al* 1997:319).

S/he forsakes all interest in the future and remains absorbed in the past. Of note to this study is that this inability to "progress" does not stop with the "self" in terms of extreme helplessness, loss and vulnerability, but also affects the victim's dealings with other people (McCann *et al* 1990:139) such as family members. The victim must therefore face his/her own "vulnerability" to such "loss", both in his/her own life and in the life of those s/he loves.

2.9.2 The ripple effect of trauma

The change in perception as a result of the "violation experienced through victimisation reverberates from the "self" to all relationships in the victim's life" (Reid 1997:26). This reverberation, which can take the form of aggression, abuse, withdrawal or other significant behavioural changes after a traumatic experience, usually prompts people to reach for support – ideally from the family. However, even in supportive endeavours with family members relational difficulty is experienced in some areas. Some of these, which have been observed by Parson (1998:245) and McCann *et al* (1990:141), are: social withdrawal, avoidance, interpersonal discomfort and intimacy, stress, child rearing, marriage problems, and finally, vocational failures. The significance of observations such as these for the primary victim's areas of *difficulty* becomes more relevant when analogies with the secondary victim's areas of *need* (Herbert *et al* 1999:33-38) are drawn. These areas of difficulty/need appear to be contradictory. The secondary victim needs: fun, closeness and intimacy, relaxation, communication, and finally, trust and a sense of predictability. Given this contrast, it becomes evident that traumatic events lead to a multitude of changes within the relationship with the victim's closest associate.

So how do most of these changes, specifically the searching for and healing of memories, occur within the family setting? Smith (Friedman 1996:37) and also Bisson and Shepherd (1995:719) say that the family serves as a cure for trauma by detecting symptoms, confronting the problem, reviewing the traumatic event and resolving trauma-inducing controversies connected with the event. Hyer (1994:309) warns that if the family does not help with the finding of a meaningful resolution to the incident, healing will not occur and trauma memories will continue. Gill (1991:21) mentions being able to "function without feeling

devastated by the memory of the event" as one of the seven steps to knowing whether the trauma has been resolved. Clearly the family serves as a shield for the primary victim. It goes without saying that within the family the person who must assume the above mentioned awesome responsibility is the partner.

The researcher Zlotnick (1997:37) narrows the influence of the family down to the partner. He confirms that the availability of the partner as the protective shield will have a positive correlation to better post-trauma adjustment. The protective shield refers to the level of emotional, economic, personal and social support available to the victim through the partner. Figley (Friedman 1996:37) agrees that a supportive partner will accept the stressor, have high tolerance and be committed, affectionate and flexible, acting as a type of "membrane" around the victim. Zlotnick (1997:37) claims that most unresolved traumas are likely to occur in those who are single, again confirming the importance of the need of a trauma victim for a "protective" loved one for recovery after the trauma. However, despite the need for positive family input, it is not uncommon, says Herbert *et al* (1999:32), for marriages and partnerships to break up or for the partners to become alienated from each other after a trauma.

Indeed, following a traumatic incident, the loved one has a pivotal role to play as part of the wider social support system. Five major functions of social support were isolated in a study by Burge and Figley (Friedman 1996:37). These functions include emotional support, encouragement, counselling, friendship and physical assistance (Friedman 1996:37). Miller (1999:24) asks if the partner is expected to provide protection, support, healing, encouragement, empowerment and optimism in the face of adversity and at what cost will it be to his or her own ability to work through the secondary trauma facing him/her.

2.10 "BEYOND THE VICTIM": the traumatic effects of crime on the secondary victim

It is time to turn people's attention away from their exclusive preoccupation with the pathology of the victim and begin planning how to care for the pivotal support system – the secondary victim. Secondary victims experience alterations in their own cognitive schemas or beliefs, emotions, expectations and relational assumptions about self and others. It is time to supplement knowledge of the primary victim with new insight into the effect of trauma on the

secondary victim. This data should result in more effective measures towards assisting both of the "vulnerable victims" when they are left feeling unprotected after experiencing a traumatic incident, the object being to help them to realise that their apparently abnormal behaviour in response to the violent incident is actually normal.

One knows through literature that when a family member falls prey to a traumatic incident, the entire family experiences the aftermath. The shattering of the illusion of invulnerability causes the loved one to expect the worst. Vital functions such as nurturing, education and protection can be disturbed. Communication, role distribution, intimacy and expressiveness may be reduced in order to cope with the new demands. Some partners/spouses may even try to balance their absorption by providing the children with more comfort and nurturance, or on the other hand they may control, overprotect, restrict and limit family members in such a way that they become more dependent. For example, children of Nazi concentration camp survivors (Danieli 1985) and Vietnam combat veterans (Kehle and Parsons 1988) experienced social and psychological difficulties as a result of their exposure to their parents' traumatic experience (Dyregrov http://www.icisf.org/acrobat%20documents/terrorism). However, a study by Kliewer (in Dempsey, Overstreet & Moely 1999:157) showed that the parent can make a significant contribution towards preventing these difficulties. They found that children who could talk to their caregiver about violence displayed fewer post-traumatic stress disorder symptoms than those who could not. The important role of the mother as caregiver was further emphasised by Dempsey *et al* (1999:155) who found that a mother's absence (physically or emotionally) was associated with higher rates of post-traumatic stress disorder symptomology in traumatised children.

Again in relation to the female figure, Peterson (1993:196) refers to Figley (1978), Stanton (1975) and William (1985) who all found that wives of war veterans suffering from post-traumatic stress disorder experienced problems associated with their husbands' traumatic state. These include physical abuse, neglecting their own emotional needs to focus on crisis responding, feeling guilty that problems are their fault and feeling overwhelmed at becoming the pivotal emotional support of the family. In women partners there was a feeling of frustration at their inability to help. As a result, problems occurred with regard to intimacy, unfaithfulness and severed dyadic patterns (Peterson 1993:197). Victims often struggle with profound questions at this stage and reach a deeper level of awareness and existence.

Sometimes this "change" in insight is not understood and can lead to communication difficulties not previously experienced within the relationship.

Research has shown that aspects of the trauma can be acted out between the victim and the partner through engagement in patterns such as trauma transference (Figley 1988:637). This involves the passing on of one's own emotion to another person. The primary patterns of trauma engagement include allies/enemies, aggressor/aggressed and rescuer/rescued. In transference the primary victim wishes to depend on the secondary victim so that s/he can "let go" of the self-care system and get well again. In letting go s/he may begin to engage with the partner through the above-mentioned patterns of communication. The partner may respond by attempting to avoid further pain – often caused by transference – through avoidance and impulsive behaviour. This is particularly so for the woman whilst the man often disregards his own reactions. Men are not particularly good at asking for their needs to be met, they tend to give advice and become pro-active after trauma, while women listen more and are less action oriented.

To enable partners to circumvent some of the harmful reactions of transference they need to be given an understanding of what effects trauma can have on their relationship. The resultant diagnosis of the syndrome of traumatic effects on the partner as secondary victim is referred to as secondary traumatic stress disorder, which is **the least documented affective disorder experienced after trauma.**

2.10.1 Secondary traumatic stress disorder

The syndrome described by Figley (1999:2), as secondary stress disorder has not yet received much attention from the psychiatric community. Although explained earlier (as secondary traumatisation section 2.2.2), for the sake of clarity the meaning will be briefly revisited. Secondary stress disorder (secondary traumatisation/traumatic stress) consists of the natural behaviours and emotions resulting from *knowing about a traumatising event experienced by a significant other*, and from helping or wanting to help the traumatised person (Figley 1999:9). Besides these characteristics secondary traumatic stress has three further causative factors:

- Being indirectly confronted by actual or threatened death or injury, or by a threat to

the physical integrity of others

- A stressor provoking a response of fear, helplessness and horror
- Indirect exposure, to exceptional mental or physical stress whether brief or prolonged (Figley 1995:8).

Secondary traumatic stress can therefore involve a "rapid onset of post-traumatic stress disorder symptoms, as well as feelings of helplessness, confusion and isolation from supporters, and arousal symptoms typical of post-traumatic stress disorder sufferers" (Figley 1995:7). Studies by Helzer (1986), Fay (1991) and Boulanger and Kadustin (1986 in Hyer 1994:109) agree with Figley. Their findings show that under low or moderate stress, predisposing factors produced post-traumatic stress disorder reactions, but in extreme conditions (such as experienced in carhijacking or armed robbery), everyone, even the family member who seems to be the least susceptible, can develop post-traumatic stress disorder or, more accurately, secondary traumatic stress. So then secondary traumatic stress in this study refers to the experiencing of post traumatic stress symptoms/acute stress by the secondary victim.

The focus of the writings so far has been on the primary victim and the ripple effect that his/her trauma has on the secondary victim within the system. It becomes the role of the educational psychologist to work with the trauma experienced by the family.

2.11 THE ROLE OF THE EDUCATIONAL PSYCHOLOGIST IN RELATION TO SYSTEMS THEORY AND THE TRAUMATISED FAMILY

What has emerged from literature on the effects of violence on the victim and his/her partner is how profound the influence of the family and its social support is, and how the family as a system reacts.

One theoretical perspective, particularly useful in helping us understand individual people in relation to their social and political context, is the ecosystemic perspective. This perspective takes an important place in the development of educational psychology theory as a whole. Systemic theory believes that people are shaped by – and are shapers of – their social context.

In their attempts to understand human behaviour, theorists with this perspective link the individual to his or her social context. Thus how one thinks, feels, behaves and develops as an individual after trauma is linked to the social structures and relationships within the family, other social and political structures and other relationships.

Although composed of individual members, a family will tend to function in ways which preserve its own characteristic patterns of functioning as a whole. The system itself also interacts with other systems outside it. Thus grandparents, parents and children may be seen as subsystems within a family, while the family as a whole may interact with external systems such as other families or a school.

In essence the systems theory sees the functioning of the whole as "systems" dependent on the interaction between all parts. To understand the whole we must examine the relationship between the different parts of the system, because whatever happens in the one part will affect all other parts. In relation to this research this implies that if the victim is affected, then simply by being part of the whole, others (the partner) will also be affected.

A fundamental principle of systems thinking is that cause and effect relationships are not seen as taking place in one direction only. They are rather seen as occurring in cycles. In systemic thinking actions are seen as triggering and affecting one another in cyclical, repetitive patterns. Such repeated patterns can effectively regulate the system as a whole. The systemic perspective is relevant to understanding the development of people in more holistic terms. Their origins, maintenance and solutions to educational and social problems as well as their economic and political needs, are inseparable from the broader context and systems (Apter 1982:69).

Since all these things are interdependent, changes at one level will always have ripple effects through a number of other levels. "Improvement in any part of the system can benefit the entire system" (Apter 1982:69). As ecosystemic theory stresses, what is at stake is finding a better fit between individuals and their whole social context. All these factors add up to a very different view of "whose problem is the problem" and how one goes about addressing

crime-related trauma within a system.

An example follows of how a change in one part of a system affects other parts. Direct exposure to criminal violence takes its toll on one member of the system namely the primary victim. While the process of secondary traumatisation produces reactions of grief, anxiety, rage and outrage which grow as the second part of the system, the secondary victim repeatedly hears about the other person's (his/her partner's) pain and loss (Saakvitne *et al* 1996:41).

The effects of trauma on the "system" are not fully understood, but some progress has been made. Today research is on the threshold of a transformation of consciousness with respect to understanding the effects on the primary victim in relation to the secondary victim.

2.12 SUMMARY

This chapter has aimed to explore questions set out in chapter one. It provides an overview of violence and crime-related trauma and its effects on the victim and his/her partner. The effects experienced by the secondary victim, as helper, can be broadly classified as secondary trauma while post-traumatic stress disorder/acute stress disorder is the experience of primary victims. This chapter also takes account of systems theory. An attempt is made to examine the emotional (arousal, anxiety, anger/retaliation, depression), cognitive (intrusion, avoidance and dissociation) and interpersonal effects relating to the self (vulnerability and loss of self-efficacy) of the primary victim and his/her closest associate in the family, the partner.

Literature has revealed the need for an investigation that probes beyond the victim to the reactive ramifications of *a violent crime-induced traumatic incident for the loved one of the victim* – the partner. This is the area of study for Chapter 3 in which the following elements of the research study into trauma as a phenomenon will be introduced:

Who ? (sample group)
What ? (measuring instruments) and
How ? (research methodology)

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 INTRODUCTION

The statistics provided in chapter one (section 1.2.2.1) show the magnitude of crime-related trauma, as experienced in carhijacking and robbery in South Africa. The literature survey in chapter two highlights the fact that the psychological impact of crime-related trauma has far-reaching implications, extending as a ripple effect from the victim to the loved ones. In fact, previous research has shown that persons close to the victim, such as family members, may suffer signs and symptoms of traumatisation similar to those displayed by the primary victim.

In light of the above, this study, which is both quantitative and qualitative in nature, aims at investigating the signs and symptoms that the secondary victim experiences, in an attempt to gain an understanding of what happens emotionally, cognitively, as well as interpersonally, to the partner of a primary victim who experiences crime-related trauma.

This research chapter begins by stating the purpose of the study and by referring to the relevant research questions. Following this, the characteristics of quantitative methods and the advantages and disadvantages of the quantitative approach are discussed and subsequently considered from a qualitative perspective. This is followed by the methodology section, which includes a discussion of the data collection methods, such as sampling procedures and composition. It also covers the instruments and techniques for data capture and analysis, the administration of the questionnaires, and the validity and reliability of the design as well as the use of triangulation as a means of enhancing the validity of the research.

3.2 PURPOSE OF THIS STUDY

As a researcher my aim was to investigate the effects of crime-related secondary trauma on the partner of the victim. Since no research had been done on how the experience of traumatic incident affected the loved one (i.e. the partner/spouse), one could expect to gain a wealth of new, in-depth information by using predominantly quantitative research methods. The data obtained, when analysed, highlighted the effects pertaining to trauma, cognitive (acute stress reactions), emotional (depression, dissociation) and interpersonal (vulnerability, loss) aspects of the trauma, as well as the related problems pertaining to various general factors such as amongst others, age and gender. This was investigated through the information provided by the three questionnaires. A predominantly quantitative analysis procedure was used to determine the difference between the primary and secondary victims of trauma.

3.3 THE RESEARCH QUESTION

3.3.1 The main research question

The research question can be stated as follows:

What are the effects of a violent crime-related traumatic incident on the partner of the primary victim?

3.3.2 Secondary questions

Leedy (1997:55) proposes that research problems are too complex to be solved without subdividing them into secondary questions. Consequently this study used secondary questions in order to gain insight into how the loved ones' (secondary victims') cognitive, emotional and interpersonal relations are affected, and what happens to them in terms of acute stress, trauma, loss, depression and vulnerability.

- Who do the respondents turn to for advice?
- How do they cope after a violent incident?
- Do the respondents develop psychosomatic symptoms after a traumatic incident?

- Does the partner experience trauma, loss, acute stress, and vulnerability to a degree similar to that experienced by the victim after exposure to a crime-related traumatic event?
- Is the partner in danger of experiencing symptoms of post-traumatic stress or acute stress disorder?
- Will a sense of derealisation increase according to the severity of the event?
- Are depression and anxiety experienced as underlying symptoms?
- What other variables – age, gender, perception of the severity of the event, time lapse and others - can affect the level of trauma in the primary and secondary victims?
- Which factors in general affect victims of crime-related trauma?
- Does gender influence the level of trauma in the partner and the victim?

3.4 USING BOTH QUANTITATIVE AND QUALITATIVE METHODOLOGY TO ASSESS THE EFFECTS OF TRAUMA ON THE SECONDARY VICTIM

3.4.1 Characteristics of quantitative methods

"By the mystery and expressiveness of numbers we can express what is indescribable and predict what is reasonable – in other words, statistics is a language that can speak when other tongues are mute" (Leedy 1997:243). This means that quantitative research can take the indescribable everyday experiences, such as crime, and translate these experiences into a numerical form of expression and thereby turn the "indescribable" phenomenon behind trauma into facts that become comprehensible. Quantitative methods measure "how much", "how often" and "how many". It is a language of facts and relationships, providing the reader with a foundation of knowledge from which to interpret. This information provides the grounding for therapeutic intervention.

Quantitative research is concerned with the discovery of general laws (nomothetic), commonalities and consistencies, the researchers take an outsider perspective by assuming that a value free science is possible and the research, which aims at prediction and control, emphasizes the measurement and analysis of causal relationships. Quantitative research with its emphasis on objective, empirical, scientific and universal truth has led to far-reaching technological and scientific developments worldwide.

3.4.1.1 *Advantages and disadvantages of quantitative methods*

The aim behind any type of research should be to solve problems. To this end quantitative research aims at providing established facts and at indicating through measurement the nature of the problem to be solved (De Vos 1998:141). "Guessing" is avoided at all costs. Instead studies are focused on specific hypotheses or questions. Measurement is objective, precluding possibility that the researcher could add his/her own, subjective interpretations. The steps put in place to control the information lead to more precise research results and limit researcher bias.

However all is not positive in the quantitative world of the researcher. According to Kaplan and Maxwell (http://www2Auckland.ac.nz/miss/isworld) the phenomenological meaning of the participants (as conveyed by the text) is lost when textual data are quantified. Quantification of data therefore minimises the personal meanings attached to the data. As such, quantitative research is seen as reductionistic in its approach to the study of behaviour, losing sight of the whole picture. In addition the quantitative emphasis on measurement is believed to oversimplify social reality, strip away the context from the data, and objectify the research subjects. In addition, an "epistemological scepticism" towards the attainability of "objectivity" and "truth" in scientific statements has grown. Instead, a more practical view has been adopted.

A purely quantitative approach at this stage of development of the research on the criminal violence phenomenon could be inappropriate since the "severity" of secondary trauma cannot be measured by any single dimension. "Simplistic efforts to quantify trauma ultimately lead to meaningless comparisons of horror" (Herman 1992:33-34). The methods of how we study people of necessity affect how we view them.

When we reduce people to statistical aggregates we lose sight of the subjective nature of human behaviour. Furthermore, even in quantitative research, in investigating complex human phenomena one rarely has the opportunity to select a truly random sample, thereby limiting the generalisability of the results of data collection.

3.4.2 Characteristics of qualitative methods

Mouton (1996:107) describes a research design as a set of guidelines and instructions to be used in addressing the research problem, and Le Compte and Preissle (1993:55) expand on this definition, by suggesting that the process includes the putting together, mentally and on notepaper, of as many aspects as possible of the researcher's planning and preparation. In addition, Creswell (1994:12) proposes that a qualitative research design should be flexible in order to capture the essence of the secondary victim's experience, thereby enabling the researcher to develop an understanding from the participant's point of view. Furthermore, according to Kerlinger (1986:479), the main purpose of any design is to enable the research question to be answered in a manner that ensures that the validity of the research is not compromised in any way.

In this case, the design will be exploratory/descriptive in nature, making use of questionnaires as well as informal individual interviews (in the form of debriefing) and telephone interviews as techniques for collecting data.

According to Marshall and Rossman (1995:143) the trustworthiness of a study can be evaluated by asking the following questions: Can the findings be generalised to the rest of the population? Are the findings valid and reliable? In considering these questions, let us first take a look at advantages and disadvantages of qualitative research, the methods of data collection, at sampling (the sample composition will be considered), at validity and reliability, and thereafter, at triangulation as a method of enhancing the validity of the design.

3.4.2.1 *Advantages and disadvantages of qualitative methods*

Reflexivity is a distinctive feature found in qualitative research. It can be understood as an attempt to make explicit the process involved in the whole research project. Making explicit can be seen as "reflecting on and critically evaluating" the research topic, the design and the process, together with the personal experience of doing the research. In other words, reflexivity implies that the researcher reflects on his/her own experience as well as the influence that her/his presence has had on the process (Russell & Kelly 2002 http://www.qualitative-research.net/fqs-texte).

As a researcher, I believe that no researcher can investigate a sensitive, emotionally charged topic such as crime-related trauma and remain neutral and uninvolved, since feelings will inevitably be experienced, and values will be communicated, albeit on a non-verbal or even subconscious level. This subjectivity can lead to bias interpretations of information, particularly since the victim's perception provides the findings (chapter four will show how perceptions shape results).

In qualitative analysis the researcher attempts a holistic understanding of the topic by means of a flexible research strategy and data collection. Participant observation, debriefing and telephonic interviews yield in-depth knowledge that is difficult to measure.

3.4.3 Data collection

Data were collected from the sample group by using the techniques discussed below, namely qualitative and quantitative interpretation of standardised questionnaires, observations, debriefing sessions and telephonic interviews. Qualitative methods are not discussed in detail as they were simply used on an informal level to provide depth to the study.

3.4.3.1 *Sampling*

According to Bless and Higson-Smith (2000:84) the sample must fit in with the other components of the study (validity) and there must be internal consistency and logic across the study phases. In other words, one must decide who to interview or question and which sampling technique to use.

Non-probability, convenience sampling (availability sampling) was used for the purposes of this study. "Non-probability" refers to the fact that the sample is not randomly selected, and "convenience sampling" implies selecting a sample, on the basis of convenience and specifically from victims who were robbed as not everyone in society was attacked. According to Maykut and Morehouse (1994:56) this convenience approach to sampling acknowledges the complexity that characterises trends in the behaviour of individual persons and of society at large, as well as the limits of generalisability. The same authors note that the

generalisability of the results of investigating complex human phenomena is constrained by the dearth of opportunities to select a truly random sample.

The following checklist proposed by Miles and Huberman (1994:235) for designing a sampling plan was utilised in selecting the sample for this study:

- Is the sample relevant to your conceptual frame and research questions?
- Will the phenomena you are interested in appear?
- Can believable descriptions and explanations be produced, ones that are true to real life?
- Is the sampling plan feasible with respect to time, money, access to people etc?
- Is the sampling plan ethical concerning informed consent, potential benefits and risks, the relationship with informants?

3.4.3.2 *The sample group*

The focus was on the uniqueness of each individual and situation within the target population. The target population were primary and secondary victims of robbery, and results of the findings should be applicable to the target population. In this study, volunteers were requested by word of mouth, by advertising in the press, and by conducting telephone conversations with the Trauma Clinic of the Rand Afrikaans University a community security service, doctors' offices, schools, sports clubs and churches. Referrals were made from Lifeline Crisis Centre on the East Rand. Participants haled from the Johannesburg and East Rand areas.

The subjects were telephoned by the researcher personally and asked to participate in the study. The purpose of the study was explained to them. Subjects were asked about the event on the telephone. If they agreed to participate, a questionnaire was delivered to them personally. Note: if both the partner and the victim were directly involved in the incident they were not included in the sample group.

3.4.3.3 *Defining the sample population*

It is imperative that the sample population be introduced to the reader, as they form the foundation of the study. The knowledge gleaned from this will shed some light on the "frame of reference" from which each subject has responded to the questionnaire, as interpretation of the traumatic incident will occur within this context.

3.4.3.4 *The sample composition*

The research was done in Gauteng (South Africa) in Bedfordview, Benoni, Boksburg, Brakpan, Florida, Mondeor, Randburg and Springs. Initially 280 questionnaires were presented to the victims and their partners (140 couples). One hundred and eighty six responses were received back from 93 couples. Mouton (1996:22) notes that the phenomenon of "reactivity" refers to how the participant in a study reacts to the questionnaire. The reaction can manifest in a variety of forms, for example, enthusiasm, resignation or outright resistance to completing the questionnaire. These phenomena were clearly represented in the study where 66% of the sample group completed and returned the questionnaire. However, De Vos (1998:11) notes that a response rate of 50% is considered adequate, a response rate of 60% is good and 70% is excellent. In light of this claim, the response rate was very good.

The ages of the participants ranged from 18 to 50 years. The highest incidence fell in the 30 to 39 age group. One hundred and one were female and 85 were male victims. Of the 186 participants, 151 were white, 31 were black and four were from the asian population group. Their monthly income fell between R5 000 and R 30 000, with the highest category (58) falling in the income group ranging between R5 000 and R10 000. Qualifications of the combined group of victims and partners ranged from pre-matric to sixty-five (35%) having a degree or a post-graduate qualification. Eighty-seven percent (87%) of the primary victims had been in the relationship with their partner for longer than two years.

3.4.3.5 *Techniques for data collection*

As already mentioned, this project made use of informal observations, debriefing sessions, telephone interviews and questionnaires to gather data. During debriefing the respondent

explains the details of the incident to the researcher in the first session. During the second session both client and researcher explored the effect of the event on the lives of the victims. Observations were made on an informal basis. The initial telephone interview related to what happened to the respondents. After the questionnaire had been completed an informal or follow up interview was undertaken, respondents were asked if there were any areas of concern with regard to the questionnaire. If some underlying emotions were re-experienced through the research these were dealt with immediately over the phone.

3.4.3.6 *Questionnaire administration*

Questionnaires were delivered by hand to the sample group because as noted by De Vos (1998:155) higher response rates are achieved with, personal contact. This method of data collection gave respondents an opportunity to clarify issues of uncertainty. Questionnaires were colour coded to make it easier to identify which questionnaire was to be completed by the secondary victim, who was not at the incident or the primary victim, who was directly involved in the incident (See *appendix B for questionnaires).*

The basic objective of the questionnaires was to "obtain facts and opinions about a phenomenon from people who are informed on the particular issue"(De Vos 1998:153). In this case people who had been directly or indirectly involved in crime were classed as the "informed on the issue" and they provided the "facts and opinions" for analyses from the questionnaires. Both primary and secondary victims were given a self-administered questionnaire to answer.

3.4.3.7 *Measuring instruments*

Before analysing the results, it is necessary to describe the instruments used to evaluate the subjects.

- ***Standardised questionnaires***

In this study, three standardised questionnaires, namely the Schillace Scales, Beck's Depression Inventory (BDI) and the Stanford Acute Stress Reaction Questionnaire (SASRQ)

provided rich and meaningful information. The researcher used the information obtained from these questionnaires to determine the relationship between biographic classifiers (age, gender etc) and the emotional reaction (trauma, loss etc) of the victims.

Self-administered standardised questionnaires are easily administered and allow the researcher to obtain information that can be further investigated qualitatively. Questionnaires provide a quick and accurate idea of the theme to be followed up in the interviews. On the other hand, they are impersonal and do not capture the richness of the respondent's insight and experiences, because the respondent has a limited range of responses from which to choose in order to categorise her/his replies (experiences, attitudes etc). In this research, the questionnaires alone did not elicit the quality of information that is necessary to gain insight into the uniqueness of the partner's lived experiences, hence they were used in conjunction with telephonic debriefing and observation interviews.

The researchers explanation of why each questionnaire was chosen, what it measures, its reliability and validity and the scoring procedure follow.

- ***Stanford Acute Stress Reaction Questionnaire (SASRQ)***

This questionnaire was chosen for three reasons:

1. It includes the measurement of all symptoms of post-traumatic stress disorder, in particular dissociation, an important symptom for the purposes of this study since it could have a direct impact on the partner.
2. It provides an overall indication of the perceived severity of the traumatic event for the victims.
3. It is non-ambiguous and takes very little time to answer.

What the SASRQ measures:

Besides determining the presence of acute stress disorder (ASD), the SASRQ also provides information regarding the following:

1. The presence of a traumatic event and the psychological impact on the individual, "symptoms such as distress, trauma, flashbacks, difficulty carrying out everyday tasks, insomnia, and poor concentration"(Ginzburg 2002) are investigated.
2. Dissociative traits, including numbing, reduced awareness, derealisation, depersonalisation and dissociative amnesia, avoidance and hyperarousal.
3. An overall *dissociative* indicator is provided.
4. Other trait indicators are: *re-experiencing (intrusion/flash backs), avoidance* and *anxiety.*
5. Finally, an overall *acute stress score* is given, showing whether a combination of the above symptoms or each symptom individually, is absent or present (Stamm 1996:293).

Reliability and validity: Cronbach's alpha = 0.92 (result found by the developer of the questionnaire). The standardised test therefore shows high validity. The SASRQ has significantly predicted the incidence of long-term post-traumatic stress disorder in primary victims of trauma.

Scoring: The scale gives a rating on a 6-point likert scale of how disturbing the event was for the individual. Symptoms are scored from these values as "absent" or "present"(absent if < 3; present if > 3).

- ***Schillace Scales***

This questionnaire was chosen for the following reasons:

After a negative traumatic experience, individuals often report a sense of insecurity and defensiveness along with an expectation that they will be hurt again. This perception may result from a painful event because a positive situation has changed (loss) after a negative stimulus has occurred (trauma), and it is often recognised as a state of perceived vulnerability. Therefore, this particular questionnaire was selected as it measures all three states: *loss* and *trauma,* as well as the resulting sense of *vulnerability.* Also the relationship between the variables of age, gender and proximity of time and the occurrence of the reaction are considered. The *loss, trauma* and *vulnerability* scales developed by Schillace assess the

subjects' perceived states of reaction toward life events thought to have significant impact (Schillace 1994).

What the Schillace Scales measure:

The three scales consist of 30 declarative statements answered "true" or "false" according to the subjects' perception at the time of administration. Items in the *loss scale* originated from clients' reports of reactions to life experiences, specifically traumatic incidents involving *an undesirable change in an important relationship.* The *trauma scale* was similarly conceptualised and developed with the aid of clinically recorded statements made by clients in response to events that were physically injurious, and/or psychologically threatening to them. The *vulnerability scale* is an experimental instrument intended to measure the state of vulnerability. The scale consists of statements made by individuals reacting to trauma and loss as life events (Schillace 1994).

Reliability and validity:

During standardised development of the questionnaire by Schillace all three parts of the questionnaire (loss, trauma and vulnerability) were found to be reliable and valid.
The results were the following:
Cronbach alpha = 0.88 was obtained for split half reliability for the loss scale, Cronbach's alpha = 0.87 was obtained for the trauma scale and Cronbach's alpha = 0.79 was obtained on the vulnerability scale.

These preliminary results by Schillace suggest the loss scale has adequate reliability and validity as a general measure of reaction to events perceived as the removal of positive conditions. The reliability and validity characteristics of the trauma scales render them suitable for use as an experimental measure of the clients' reaction to events experienced as traumatic. The vulnerability instrument is useful in gauging a specific reaction to disruptive life events resulting in a sense of defenselessness (Schillace 1994).

Scoring:
1 point is scored for "False" and "True" scales.

- ***Becks depression inventory (BDI)***

Why the questionnaire was chosen:

The depression inventory was chosen as it can determine whether the primary victim and his/her partner present with depressive symptoms after being violently victimised. The *BDI* measures the presence and intensity of depression. It relates to affective, cognitive, motivational and physiological symptoms of depression. The test consists of 21 categories of symptoms, attitudes and behavioural manifestations of depression.

What the BDI measures:

The following areas are measured through the inventory: mood, pessimism, sense of failure, lack of satisfaction, feeling guilty, sense of punishment, self-hate, self-accusations, self-punitive wishes, crying spells, irritability, social withdrawal, indecisiveness, body image, work inhibition, sleep disturbance, fatigability, weight loss, somatic preoccupation and loss of libido.

Reliability and validity:

According to Baron and Perron (Hammond & Romney, 1995:670) it has been validated as a reliable self-report measure of depression.

Scoring:

The person must grade him/herself according to a list of four graded statements. The numerical value ranging from 0 –3 is attributed to a statement depending on the degree of intensity. The scores are summed ranging from 0 to 63. The higher the score the more severe the depression.

- 0-9 indicates no depression
- 10-15 mild depression
- 16-23 moderate depression
- 24-63 severe depression

Now that the reader has been introduced to the measuring instruments behind the findings, the techniques used in the analysis will be discussed.

3.5 STATISTICAL ANALYSES

3.5.1 Data capturing, derived emotional score variables and statistical analysis techniques

De Vos (1998:203) maintains that analysis provides answers to research problems, so that conclusions can be drawn. In order to arrive at statistically sound conclusions several statistical analysis techniques were used. Research questions were stated as hypotheses and then tested using the appropriate techniques as described below. The generally accepted significance level of 5% was decided on as prescribed in hypothesis testing.

The full record of these statistical techniques, namely, contingency tables and chi-square/and or trend-tests; paired difference tests, analysis of variance and regression analysis, along with the hypotheses evaluated by a particular technique, will be presented in section 3.5.2 and further.

3.5.2 Data capturing

The techniques used to capture data and derive emotional-score variables from the original data will be briefly discussed to provide some background when interpreting the results of analysis in Chapter four.

1) The raw data was hand-scored into a typist column on the questionnaires and then electronically entered into a text file by data capturers.
2) Quantitative analyses and data manipulation were performed by means of the SAS statistical software package. This package provided the researcher with exploratory descriptive statistics as well as all the statistical-technique results mentioned in section 3.5.1.
3) The data itself:

a) Biographical information was entered into separate variable fields and assigned appropriate descriptive labels, for example, *age*.

b) Emotional or stress-related score variables were calculated programmatically according to standards as provided by the developers of the Stanford Acute Stress Reaction Questionnaire (SASRQ); Beck Depression Inventory (BDI) and Schillace Scales. An explanation of how this scoring was done is explained as follows:

- **Trauma score** on the trauma test (or T-score):
  For each respondent a trauma score was calculated as the number of correctly indicated "true" or "false" responses recorded in the test.
  Possible maximum and minimum score values range between 0 and 37.
  Low levels of trauma = 0-12
  Moderate to High levels of trauma = 13+

- **Loss score** on the loss test (L- score):
  The score was derived in a similar fashion as the trauma score. Possible minimum and maximum score values range between 0 and 30.

- **Vulnerability score** on the vulnerability test (V- score):
  Scores were calculated in a similar manner as the trauma score. Possible minimum and maximum score values range between 0 and 24.

- **Depression scores** on the depression test (D- sum):
  Original response values ranging from one to three were transformed to values ranging from zero to four. For each respondent the transformed values were then summed to produce a depression score. Possible minimum and maximum score values range from 0 to 63.

- **Acute stress score** (A-score):

Two scores were ascertained from the scores provided by the acute stress questionnaire. The first was the extent to which acute stress symptoms were absent or present *(acute stress symptoms test – (a))* after a traumatic experience. Once this

information was established the researcher wanted to understand to what extent each of the acute stress symptoms (e.g. dissociation) were absent or present in the respondents (*acute stress score variable – (b)*). The analyses then considered how the absence or presence of symptoms as revealed by the scores was affected by factors such as gender and age. Details of how these analyses were done are given below.

a) **Acute stress symptoms test** (A-score):

Original symptom-responses were transformed into symptoms being absent or present (0 or 1 value). The responses were then grouped into five dissociative traits as well as the traits of re-experiencing the trauma, avoidance, marked anxiety/arousal and impairment in functioning as set out in the guideline by Koopman and Cardene (2000) (developers of this questionnaire).

b) **Acute stress score variable:**

The acute stress score was calculated for each victim and partner as the total number of stress symptoms present for a particular respondent.

The statistical analyses explained from section 3.5.2.1 up to and including section 3.5.2.4 serve to inform the reader as to what each analysis conveys.
(See Appendix C for scoring the questionnaires).

3.5.2.1 *Frequency tables, chi-square tests and trend tests:*

These tests tell the researcher the proportion of cases which were observed in a particular area and how meaningful these results are. For example, how many victims and partners wanted to retaliate and is this result meaningful.

One-way frequency tables were calculated for the biographical classifiers and emotional variables. Cross-tabulations were also done on combinations of these biographical and emotional variables. In the initial exploratory statistical-analysis stage, these tabulations

provide insight into the general spread and variability of the different variables. It also provides a valuable means of validating and editing the electronically captured data. Extreme values can easily be identified from the tables and checked for accuracy.

In each tabulation Pearson's chi-square statistic was calculated. It tests the null hypothesis (H_o) of no dependence between the row and column variables in the table, against the alternative hypothesis (H_1) of dependence between the two variables. (In other words, whether a biographical classifier (for example age) has an effect on an emotional score (for example avoidance).

When applicable, the Cochran-Armitage Trend test was also calculated and then used to evaluate the null hypothesis (H_o) of no trend over the levels of the row variable for the two levels of the column variable in the cross-tabulation against the alternative hypothesis (H_1) of row trend being present and significant.

Please refer to Summary **Table 4.6** for a complete list of tabulations and cross-tabulations investigated.

3.5.2.2 *Paired - difference t-tests:*

The important question of whether partner and victim's emotional reaction to a traumatic situation was the same or different was addressed through the parametric paired-difference t-test and the non-parametric Wilcoxon – Signed-Rank – test. Both these tests compare paired observations – in the study paired partner and victim responses are suited to be analysed in this way. Calculations are done on the differences between the individual paired responses.

Ho: The null hypothesis relating to both difference tests states that the mean difference between the two groups – partner and victim – is not significantly different from zero. This implies that the partners/victims' response to the traumatic event did not differ significantly – they reacted in a similar way.

H_1: The alternative hypothesis being tested states that the mean difference between the two groups is significantly different from zero. This would in turn imply that the two groups

reacted differently to the traumatic event. Difference tests were done on all the paired responses for the trauma, loss, vulnerability, acute stress and depression scores, (Summary **Table 4.7** refers).

3.5.2.3 *One-way analysis of variance:*

Paired-difference test results indicated that victim and their partners did not experience traumatic events differently – thus ruling out partner/victim as a possible reason for explaining the variability in responses to traumatic events.

Other biographical classifiers were then investigated to determine if any of these variables could explain why different respondents exhibited different emotional responses to an event.

One-way analyses of variance were therefore conducted on the different emotional score variables. Included in each analysis was the possible effect of a biographical classifier. Please refer to Summary **Table 4.8** for a complete list of analyses with the associated emotional variables and biographical classifiers.

The null hypothesis (H_0) being tested by the analysis in this instance tests whether a specific biographical classifier had a significant effect (H_1) or not (H_0) on a specific emotional score variable. For example did age affect the trauma score significantly.

If a biographical classifier was found to be significant (thus explaining variability /differences in the score variable), the Bonferroni multiple comparison of means test was used to determine how the biographical classifier influenced the particular score. The test does this by indicating which group mean score – groups classified according to the biographical classifier – differs significantly from the other means. For example the biographical classifier gender was found to be significant so the Bonferroni multiple comparison of means test was used to determine how gender influenced the score of acute stress. (Please refer to Summary **Table 4.8** for a complete list of analyses performed, along with relevant significance indicated).

Note: Two-way analysis of variance using the partner/victim – biographical classifier as one classifier and one of the other biographical variables as the other classifier was not included in

the summary table since the Paired-difference t-test indicated that partner/victim classification did not significantly explain the variability in the respondents' reaction to a traumatic event.

3.5.2.4 *Simple linear regression:*

Another question to be answered by the study was whether the different emotional score variables were related. Simple linear regression was performed using the different emotional variables as the dependent and independent variables. Trauma, loss, vulnerability, acute stress and depression scores' interdependence was investigated in this way.

The null and alternative hypotheses being tested with the regression analysis tests whether insignificant (H_0) or significant (H_1) linear relations exist between the two relevant score variables in the particular regression.

Please refer to Summary **Table 4.9** for a complete list of regression analyses performed.

3.6 VALIDITY AND RELIABILITY

3.6.1 Validity

The question asked, when determining if a test is valid or not, is whether the test measures what it is supposed to measure, and whether the concept is measured accurately. The quantitative meaning of validity refers to "how true" any piece of research is relative to some presupposed objective scale of truth. Consequently, quantitative validity (where the term "validity" is grounded in the realist assumption that truth exists external to and independent of our perceptions and can be objectively discovered) is therefore not compatible with the phenomenological-interpretive (qualitative) framework, which assumes that objectivity and universal truths are not attainable.

There are two forms of validity, external and internal. External validity refers to whether the measured procedures allocate the same value to an element each time it is measured under the same circumstances. Internal validity refers to when constructs measured reveal valid measurements, the data are accurate and reliable, the analyses are consistent and the final

results are supported by the data. Where the attitude of the victim's partner is concerned, the interpretation by the researcher can only be accurately conveyed if feelings and frustrations that these loved ones experience in dealing with crime-related trauma are adequately reflected and realistically represented by the researcher.

3.6.2 Reliability

Reliability from a quantitative, positive perspective has to do with the repeatability of results a state that is obtained when the measuring instrument/s are reliable and the conditions under which they are administered are identical. It is concerned with *how well* something is measured. When focusing on social behaviour in social contexts, attempts at replicating results appear difficult, as social reality is always in a fluctuating state, and therefore instruments will never produce the same measurements. However, the term reliability requires that a measuring instrument yield only "*similar results* each time" (De Vos 1998: 85) and not necessarily produce an exact replication. In the investigation of the partner, reliability will not be entirely measured by repeatability, as no two people will have the same experience. Credibility and reliability are partly measured through data analysis.

3.7 ENHANCING VALIDITY BY TRIANGULATION OF METHODS

Le Compte, Millroy and Preissle (1992:763) propose triangulation as a strategy for enhancing validity in a study. Triangulation of methods includes the use of both quantitative and qualitative methods both numbers and words are needed to depict the complexity of social phenomena (Kaplan 1964 in Mulder 2000:87). Since there are many ways of looking at and analysing social settings, it makes sense that multiple methods are needed to capture the diversity of social life in these settings.

The call for a combination of qualitative and quantitative methods comes from researchers like Goodwin and Goodwin (in Leedy 1997:143). They believe that studies would be enhanced considerably if a combined approach were taken. Since triangulation prevents the investigator from accepting the validity of initial impressions too readily, the researcher develops a more comprehensive picture of the phenomenon of interest (De Poy & Gitlin 1994:275). These authors contend that the use of multiple methods (e.g. both qualitative and quantitative

methods) to generate information increases the likelihood of obtaining scientifically credible data and of enhancing the utility of the research.

In the present study triangulation includes the use of questionnaires, individual debriefing sessions, as well as informal telephonic interviews and observations in addition to consultation with experts and literature control. According to De Poy *et al* (1994:275) the qualitative methods will include interviews and observations, while the quantitative methods will include standardised questionnaires, namely the Schillace Scales, the Stanford Acute Stress Reaction Questionnaire (SASRQ) and the Beck Depression Inventory.

3.8 SUMMARY

Research has the potential to bring about change if relevant research questions are asked, and if correct research procedures are followed. Ultimately, the aim of all research is to make a difference in the quality of people's lives. Therefore, in this study the researcher aimed to develop an understanding of the carhijacking/armed robbery phenomenon from the partner's perspective, with the eventual goal of providing insight into the effects experienced by the secondary victim. In the long term these effects will serve as an important contribution to the counseling of the partner in the family system. Effects of certain factors (like age) on the hijacking population in general (partner and victim), were also investigated in an effort to gain an understanding of the trauma relating to criminal violence.

- Chapter 1 provides an overview of the research process, explaining how the research problem arose. It highlights the paucity in research on crime-related trauma, and the vital necessity of filling this gap in the secondary victim, in order to necessitate therapeutic intervention for the victim and the partner.

- Chapter 2 begins with the assumption that the primary and secondary victims are similarly affected. The literature refers to these effects as post-traumatic stress/acute stress in the former, and secondary traumatic stress in the latter case.

- Chapter 3, besides delineating the research process, explaining the scoring procedure and statistical analyses, explains the role of each analyses and triangulation in order to give substance to this relatively new field of research.

The following chapter, Chapter 4, focuses on the findings and the analysis of results obtained from both the qualitative and quantitative data collection techniques. Furthermore, the implications of these findings are discussed.

CHAPTER FOUR

RESULTS AND FINDINGS

Beyond the victim

4.1 INTRODUCTION

Thus far, three aspects of the study under review have been covered. Chapter one aimed to indicate that research into the impact of criminal violence on the secondary victim was necessary since this has not been an area of extensive study in South Africa. Secondly, the literature reviewed in chapter two clearly indicated that trauma could have serious consequences for the partner as the secondary victim. Thirdly, the theoretical side of the research methodology was explained in chapter three. The practical findings are presented in this chapter.

The broad goal of the study is mentioned again for the sake of clarity, this is followed by the presentation of the quantitative results (section 4.3) which includes the biographical classifiers of the participants as a background to understanding their responses. Thereafter, quantitative statistical analyses are explained further in each analysis. Included in these analyses is a brief interpretation of the results from tables (table 4.6, 4.7, 4.8 and 4.9), some of which are then illustrated in bar graphs. The qualitative findings from informal observations, telephonic interviews and debriefing sessions complete the study.

4.2 THE BROAD GOAL OF THE STUDY

The main goal of this study was to provide an analysis of the cognitive, emotional and relational effects of violent trauma on the secondary victim (the partner), to broaden the understanding of the patterns of trauma suffered by the partner and to establish what other factors affect victims of crime-related traumatic events.

4.3. QUANTITATIVE RESULTS

4.3.1 Biographical classifiers of the sample group

The following is a summary of biographical classifiers and calculated emotional variables for the sample group. These include details of the primary and secondary victims with regard to:

- The age of the group
- To whom the victims and their partners turned for advice
- When victims and their partners asked for advice
- How the primary and secondary victims coped after the incident
- The physical symptoms that developed in the primary and secondary victims

Reasons for measuring the above variables:
Apart from the age-group indicator (which is included for developmental purposes), the other variables are included because they are most likely to directly affect the relationship with the partner and, therefore, in turn affect the "system".

- Whatever the victim does inevitably affects the partner positively or negatively. For example, if the partners do not turn to each other the partner who is ignored may feel rejected or isolated. Literature (section 2.9.2) showed that post-traumatic stress disorder is influenced by a lack of social support. This suggests that if victims do not receive support or supposing that the victim does not communicate events of the incident to the partner, other pathologies may set in as the partner may have to reconstruct the event from his/her imagination, in which case the reconstruction may tend toward a worst-case scenario possibly creating unnecessary anxiety.

- Pressure on the partner increases until the victim seeks assistance. Literature (section 2.8.1) suggested that victims avoid further pain by not talking about it. This may imply that delaying assistance seeking may increase the pressure on the victim and their closest associate.

- Coping methods may be detrimental for the relationship if they are dysfunctional in terms of maintaining the relationship, or positive if methods are rational and constructive. Garland (1998:89) warned that people who are afraid of their emotions might be crippled by the trauma, this implies inappropriate coping methods, which are not in the best interest of the victim, the spouse or the relationship.

- Literature (section 2.8.1) indicated that emotional discomfort could be in the form of psychosomatic difficulties. Physical symptoms could impact on relationships, for example, by causing sexual dysfunction. Physical symptoms could also be indicative of anxiety or panic attacks, which may drive the partner away as anxiety or fear of loss could perhaps make the victim excessively possessive. Overanxious people are out of necessity completely self-absorbed and cannot relate to the partner adequately (Mc Millan 2001:12).

4.3.1.1 *Age of respondents (partner and victim)*

Table 4.1
Age of the respondents (partner and victim)

Age	Frequency	Percentage
30-39 years	63	33,87
40-49 years	44	23,66
50+ years	42	22,58
18-29 years	37	19,89

The data in Table 4.1 indicate the range of age groups that answered the questionnaire, thus providing a representative sample of the age population. Approximately 34% of the population of victims and partners are between the ages of 30 and 39, which means that in this sample the largest category of people experiencing crime were in their thirties.

4.3.1.2 *To whom the victims turned for advice*

Table 4.2 presents information concerning the person to whom victims turn after the traumatic event. For tables 4.2 – 4.5 the term *partner* refers to the secondary victim and the term *victim* refers to the primary victim. Interpretations made are read from results

recorded in either the frequency or percentage columns. Frequency refers to the number of respondents in each category. Results are rounded off to the nearest whole number.

Table 4.2
To whom the victim and partner turned for advice

Person	Frequency		Percentage	
	Partner	Victim	Partner	Victim
Therapist	14	25	15	27
Friend	22	12	24	13
Parent	9	10	10	11
Colleague	1	6	1	7
Spiritual leader	9	6	10	7
Other:				
Partner	8	21	9	23
Supreme deity	8	5	9	5
Siblings	3	1	3	1
Family member	18	3	19	3
None of the above:	1	4	1	4

Twenty four percent (24%) of the partners turn to a friend as the most important source of advice while 15% go for counselling. A spiritual leader and parent together comprise a further 20% of the people turned to by the partner. It appears that only 27% of the primary victims felt it necessary to get professional help from a therapist, and 13% turned to a friend.

Primary victims reported the partner 23%, a supreme deity 5% and siblings 1% as the people turned to for assistance. Besides the therapist the partner becomes the most important pillar of support for the victim after a traumatic incident. The question was raised in chapter one (section 1.2.1) as to whether the partner's own related issues render them ineligible to assist the victim. The secondary victim indicates turning to family members in 19% of the cases and to a supreme deity in 9% of the cases. Very few partners (only 9%) turn to the victim for advice.

4.3.1.3 *When the respondents asked for advice*

Table 4.3 gives an indication of the timeframe of when victims of crime ask for advice.

Table 4.3
When victims asked for advice

Time frame	Frequency		Percentage	
	Partner	Victim	Partner	Victim
Within a week	49	55	53	59
1 - 2 months	6	3	7	3
3-6 months	2	1	2	1
1 year +	3	3	3	3
None of the above	33	31	36	33

Table 4.3 shows that 55 of the 93 primary victims (59%) reported seeking help within the first week while 49 partners (53%) sought assistance in the same time period. Within the first six months 62% of the secondary victims and 63% of the primary victims asked for assistance. Three percent (3%) of the primary and secondary victims only asked for help after a year. It would appear that 36% of the partners and 33% of the primary victims did not seek advice in the timeframes provided.

4.3.1.4 *How the primary and secondary victims coped after the incident*

Table 4.4 gives an indication of the coping mechanisms used by the primary and secondary victims.

Table 4.4
How the primary and secondary victims coped after the incident

Coping methods used after crime	Frequency		Percentage	
	Partner	Victim	Partner	Victim
Increased aggression	15	24	16	26
Withdrawal	9	17	10	18
Working/studying	7	9	8	10
Eating more	5	2	5	2
Drinking alcohol	3	3	3	3
Other	12	7	13	8
None of the above	42	31	45	33

Table 4.4 shows that twenty-four of the primary victims (26%) and fifteen of the secondary victims (16%) reported a general increase in aggressive behaviour as their

method of coping after trauma. Perhaps perpetuating what literature referred to as the cycle of violence. Although no analysis of the relationships after the incident has been included in this study, it is worth mentioning that in the telephonic interview many of the potential respondents indicated that they were no longer living together (since these victims could not be selected as part of the sample the actual number was not recorded).

Seventeen victims (18%) and nine partners (10%) reported that they began to withdraw. Both secondary and primary victims appear to use withdrawal as a fundamental method of coping. If both the victim and the partner are withdrawing from each other it could have a detrimental effect on their relationship and could affect their rapport with other family members, such as the children – thus highlighting the "ripple effect" of trauma spoken about in literature. According to literature a typical reaction to trauma is distancing or withdrawal, as a result partners may feel rejected, the result is often further distancing, as partners may themselves withdraw as a result of being locked out of their loved one's emotional world (Herbert *et al* 1999:34). However, withdrawal may be an attempt by the primary victim to regain some control over life events.

In attempting to escape from the experiences of the trauma 10% of the victims and 8 % of the partners felt that they found comfort in their work or studies. The predictability of this situation as well as a positive goal instead of negative trauma related content of thoughts may have provided comfort. Four percent (4%) of the respondents (primary and secondary victims combined) turned to eating as a source of fulfilling the inner sense of emptiness or loneliness felt, as a result of fear and anxiety (section 2.8.1). Three percent of the combined group of victims and partners turned to alcohol (the complications of this escape mechanism are obvious). In the "other" category, the following coping methods were qualitatively recorded in the questionnaire: playing sport, smoking (i.e. forming addictions or it may be simple displacement behaviour that may be discontinued later), becoming more vigilant or pensive, "ignoring it by putting it out of mind", becoming more possessive of the loved one and minimising the event by thinking "it could have been worse". These methods suggest that the victims adopted fight or flight and compensatory or regressive behaviour.

4.3.1.5 *Physical symptoms experienced by respondents*

Physical symptoms in reaction to traumatic events are indicated in **Table 4.5**

Table 4.5
Physical symptoms that developed in the partner and the victim

Symptoms	Frequency		Percentage	
	Partner	Victim	Partner	Victim
Palpitations	9	9	10	10
Chest pains	6	4	7	4
Stomachache	5	6	5	7
Headache	12	19	13	20
All of above	9	2	10	2
Other	7	7	8	8
None of the above	45	46	48	50

Of interest is that palpitations, chest pains, stomachaches and headaches, are common symptoms experienced by the respondents and are some of the symptoms indicative of panic attacks and anxiety (section 2.8.1). The qualitative open–ended question of "other" lists heartburn as the next most common symptom experienced.

From this table it can be seen that 48% of the partners did not experience any physical symptoms this would imply that 52% did experience physical symptoms while half (50 %) of the victims did not experience any physical symptoms, suggesting that 50 % did experience such symptoms. These results therefore indicate that just more than half of the victims and their partners experience physical or anxiety related symptoms after a traumatic incident. Of importance to this study is the number of secondary victims who reported qualitatively that they experienced insomnia, fear and a feeling of helplessness and hopelessness at not being able to assist the primary victims. This in turn led to their feeling physically weak and "lifeless" – all symptoms of depression. One partner even reported being hospitalised in a psychiatric ward after an armed robbery that involved her husband.

The following results are interpreted but not tabulated (see Appendix D)

Twenty-five percent (25%) of the primary victims experienced criminal victimisation *more than once.* Thirty-eight percent (35%) of the primary victims had experienced the incident between 0-6 months prior to completing the questionnaires, whilst 65% had been victimised more than 6 months before the completion of the questionnaires. What follows has bearing on the most recent incident. Twenty percent (22%) of the primary victims had either been shot or had suffered wounds inflicted by other means. One hundred and thirty-four respondents (72%) that is both primary and secondary victims reported that the event was "very disturbing", forty-nine (26%) found the traumatic incident to be "moderately disturbing", while three (2%) found the violent episode "not at all disturbing". Of interest is that it would appear from these results that the number of secondary victims (78%) who perceive the event as "very disturbing" is larger than the number of primary victims who reported this response (66%). This suggests that reconstruction of the event from imagination, tends towards a worst-case scenario. Further results from frequency tables testify to the fact that the highest income group experienced significantly more intense trauma than the middle-income group. Probability F-test taken from the analysis of variance test reveal (F) = 0, 0009 (high income); 0, 004 (middle income); 0, 0003 (low income) for trauma, vulnerability, loss and acute stress respectively. This implies that mean scores on each of these characteristics differ significantly with respect to income groups.

An understanding of these characteristics of the sample group is imperative for any interpretation that follows from the statistical analyses. Reber (1985:385) contends that "all such data must be interpreted, facts do not stand in isolation - they are always seen in relationship to other facts." Taking into account the facts obtained from the sample group the researcher explores the traumatic effects of violent crime through the statistical procedures listed below.

4.4 THE FOUR STEPS TAKEN IN THE QUANTITATIVE STATISTICAL ANALYSES

With the hypotheses stated in Chapter 3 (sections 3.5.2.1, 3.5.2.2, 3.5.2.3 and 3.5.2.4) in mind, the quantitative results will be presented according to the sequence of the statistical analyses performed:

- First, a summary of frequency tables constructed and their associated chi-square and trend-test statistics are given in Table 4.6.
- Secondly, the results from the paired-difference t-test and Wilcoxon Signed Rank test between the partner and the victim (Table 4.7) are recorded.
- Thirdly, analyses of variance differences (Table 4.8) were conducted to show emotional variable scores.
- Fourthly, the results of linear regression analyses (Table 4.9) will be presented.

The quantitative data from the research findings of the above four analyses will be presented in the following way: first the purpose of the test is introduced, then there is an explanation of how to read the results reflected in the summarised table and significant values are discussed, followed by a graphic representation of some of the statistical analyses framed as questions in chapter three. A summarised interpretation of the results completes each section, this is necessary says Miles (*et al* 1994:72) as the final step in the statistical-analysis procedure is drawing conclusions. The aim of this stage is to integrate what has been done into a meaningful and coherent picture of the data elaboration.

4.4.1 Step one: frequency tables and associated chi-square and trend-test results (Table 4.6)

This analysis provides the reader with insight into the spread, meaningfulness, dependency and trend of the variables – retaliation, loss, vulnerability, trauma and depression - and indicates whether acute stress symptoms are absent or present in the primary and secondary victims. Then the dissociative sub-categories of acute stress disorder are measured: numbing, awareness, derealisation, depersonalisation, dissociative amnesia, intrusion, avoidance, impairment in functioning and anxiety. These results are categorised against important variables, such as time-lapse, age, gender, what happened, and how disturbing the event was for the primary and secondary victims respectively.

4.4.1.1 *An explanation of how to read the findings of Table 4.6*

A summary of the various two-way frequency tables as discussed in Chapter 3 (section 3.5.2.1) is given in **Table 4.6.**

Table 4.6 reveals the following significance values:

Key:	***	=	<0.001	(Very highly significant)
	**	=	<0.01	(Highly significant)
	*	=	<0.05	(Significant)

- **Very highly significant** results found in emotional variables are indicated where **p<0.001**. This implies that the decision regarding the acceptance of the alternative hypothesis, and rejection of the null hypothesis will be made based on the value of p being smaller than or equal to 0.001 (99.9%). Thus there is overwhelming evidence to infer that the alternative hypothesis is true.

- **Highly significant** and **significant** results are indicated where **p<0.01 and p<0.05** respectively. This implies that the decision regarding the acceptance of the alternative hypothesis, and rejection of the null hypothesis will be made based on the value of p being smaller than or equal to 0.01 and 0.05 (99% or 95% respectively). Thus, there is strong evidence to infer that the alternative hypothesis is true.

- **Not statistically significant** results are usually indicated where **p>0.05**. Thus, the p value is greater than 0.05 and therefore not statistically significant (ns).

Table 4.6
Summary of frequency tables constructed and their associated chi-square and trend-test "actual significance" values.

		Classification Variables					
	COLUMN 1 Emotional variables (scores calculated)	**COLUMN 2 Victim and partner**	**COLUMN 3 Time lapse**	**COLUMN 4 Age**	**COLUMN 5 Gender**	**COLUMN 6 Hijacked or armed robbery**	**COLUMN 7 Severity of the event (How disturbing)**
1.	***Retaliation***	Ns	0.10 0.02 *	Ns 0.07	0.0036*** 0.0048***	Ns	<0.0001*** <0.0001***
2.	***Acute stress disorder symptoms: Present/Absent*** Graph 3	Ns	Ns	Ns	0.019* 0.013**	Ns	<0.0001*** <0.0001***
3-7	**Acute stress symptoms follow:** Graph 4						
3	Dissociation (numbing-amnesia)	Ns	Ns	Ns	0.092 0.0039***	Ns	0.001***
3a	*Numbing*	Ns	Ns 0.08	Ns 0.044**	0.0097** 0.0066**	Ns	0.0487* 0.0093**
3b	*Awareness*	Ns	Ns	Ns	0.0244* 0.0172*	Ns	0.0105* 0.0023**
3c	*Derealisation*	Ns	Ns 0.10	Ns	Ns	Ns	0.0004*** <0.0001***
3d	*Depersonalisation*	Ns	Ns	0.042* 0.0067**	0.0053** 0.0036**	Ns 0.07	<0.0001*** <0.0001***
3e	*Dissociative amnesia*	0.06 0.04*	Ns	Ns	0.0377* 0.0267*	Ns	0.039* 0.0054**
4	Intrusion	Ns 0.03*	Ns	Ns	0.011** 0.0005***	Ns	0.0001***
5	Avoidance	Ns	Ns	Ns	Ns 0.0349*	Ns	0.0002***
6	Impairment in functioning	0.04* 0.028*	Ns	Ns	0.054* 0.08	Ns	0.0007*** <0.0001***
7	Number of anxiety symptoms present *Graph 2*	Ns	Ns	Ns	<0.0001*** <0.0001***	Ns	0.0002***
8	***Loss score*** Graph 5	Ns	Ns	Ns	0.0016** 0.0001***	Ns	0.0096**
9	***Vulnerability score*** Graph 5	Ns	Ns	0.0079**	<0.0001*** <0.0001***	Ns	0.0394*
10	***Trauma score*** Graph 5	Ns	Ns	Ns	0.0026** 0.0004***	Ns	0.0175*
11	***Depression sum*** Graph 5	Ns	Ns	Ns	0.08 0.05*	Ns	Ns

Column 1 of the summary table (4.6) lists the emotional variables for which frequency tables were constructed. This column (1) also indicates graphs included to highlight traumatic effects (graphs for every significant effect are not included due to the limits of the study). The headings of *Columns 2, 3, 4, 5, 6 and 7* indicate the various classification variables. What happens in this analysis is that each row (for example retaliation) is cross-classified according to the variables of: partner/victim, age, time-lapse, gender, what happened and the severity of the event.

The only non-significance (ns) or actual significance, where applicable, for the chi-square and trend-tests are listed in the body of the table. These test statistics are derived from the related frequency tables (some of which are depicted below the following associated graphs). Where actual significance values are given, the significance (probability value) associated with the chi-square test probability value is given first, with significance associated with the trend-test statistic recorded directly below. As an example for the effect of "gender" on "awareness"(vigilance), the probability of the chi-square test is 0.0244 and the associated probability of the trend test is 0.0172. The first probability value implies that the awareness of male and female respondents differs significantly, that is, they react differently with regard to awareness. The second significance value investigates the difference further and looks for trends over the levels of awareness if applicable, and it is only applicable if more than two levels exists for the variable. In this instance, the result will be ignored, because only two levels are involved as awareness is classified as present or absent. Had there been more levels – like awareness compared against severity of the event (where there are 3 levels: mildly disturbing, not disturbing, and very disturbing), this would give an indication of whether 'present'- awareness frequencies increase over severity levels and 'absent'-awareness frequencies decrease over severity levels – the more the event is perceived as severe the more awareness (vigilance) symptoms would manifest.

What follows is a detailed explanation of the *significance* in the findings of each analysis per row:

- Row 1, Retaliation:

  A very highly significant trend and ratio-differences for retaliation regarding how serious the event was perceived by the respondent was found. For gender differences a highly significant result was found for retaliation (0.0036) while a significant trend difference in time lapse was indicated for retaliation (0.02 - column 3).

- Row 2, Acute stress disorder symptoms:

  A very highly significant trend and ratio differences was found on acute stress disorder regarding perceived severity of trauma (<0.0001 for both tests, column 7) as well as a significant gender-ratio differences on the acute stress disorder measurement (0.019 column 5).

- Row 3, Dissociation:

  For dissociation a highly significant ratio differences (0.001) was found regarding perceived severity of trauma and a highly significant trend difference was found for gender.

- Row 3a, Numbing:

  A significant ratio and highly significant trend differences for numbing regarding perceived severity of event (0.0487 and 0.0093, column7). A highly significant difference was found on gender (0.0097 and 0.0066) as well as a significant trend difference for numbing regarding age (<0.044, column 4) was found.

- Row3b, Awareness:

  For awareness a significant ratio trend differences was found regarding gender (0.0244, column 5) as well as a highly significant ratio and highly significant trend differences for awareness regarding perceived severity of event (0.0105 and 0.0023, column 7).

- Row 3c, Derealisation:

  A very highly significant ratio and trend differences for derealisation regarding perceived severity of event (0.0004 and 0.0001, column 7) was found.

- Row 3d, Depersonalisation:

  A very highly significant ratio and trend differences for depersonalisation with regard to perceived severity of event (<0.0001 for both tests, column 7) was found as well as a highly significant ratio and trend differences for depersonalisation with respect to gender (0.0053 and 0,0036 column 5). Furthermore, a significant ratio and highly significant trend differences for depersonalisation regarding age levels (0.042 and 0.0067, column 4) was found.

- Row 3e, Dissociative amnesia:

  Significant ratio and trend differences for dissociation regarding gender (0.0377, column 5) was found as well as a significant ratio and highly significant trend differences for dissociation regarding perceived severity of event (0.039 and 0.0054, column 7).

- Row 4, Intrusion:

  For intrusion a very highly significant ratio and trend differences regarding perceived severity of event (<0.0001 for both, column 7) was found together with a

highly significant (0.011) and very highly significant (0.0005) ratio and trend difference on intrusion and gender.

- Row 5, Avoidance:

  A very highly significant ratio differences for avoidance regarding perceived severity of event (0.0002, column 7) and significant trend differences for gender (0.0349) was found.

- Row 6, Impairment in functioning:

  For impairment in functioning a very highly significant ratio and trend differences regarding perceived severity of event (<0.0007 and <0.0001, column 7) was found. Of note is the significant difference in impairment in functioning on the victim and the partner (0.04 and 0.028).

- Row 7, Number of anxiety symptoms present:

  A very highly significant difference in the number of anxiety symptoms experienced regarding gender (0.0001, column 5) and a very highly significant difference linked to the severity of the event (0.0002) was found.

- Row 8, Loss:

  A highly significant ratio-difference in the loss score distribution regarding gender (0.0016, column 5) was found as well as a highly significant ratio differences in loss score distribution regarding perceived severity of event (0.0096, column 7).

- Row 9, Vulnerability:

  A very highly significant ratio difference in the vulnerability score distribution regarding gender (< 0.0001, column 5) was found as well as a highly significant ratio difference in vulnerability distribution regarding age (0.0079, column 4). Finally, a significant ratio difference in vulnerability score distribution regarding perceived severity of event (0.0394, column 7) was found.

- Row 10, Trauma:

  For trauma a highly significant ratio-differences in trauma score distribution regarding gender (0.0026, column 5) was found as well as a significant ratio differences in trauma score distribution regarding perceived severity of event (0.0175, column 7).

- Row 11, Depression:

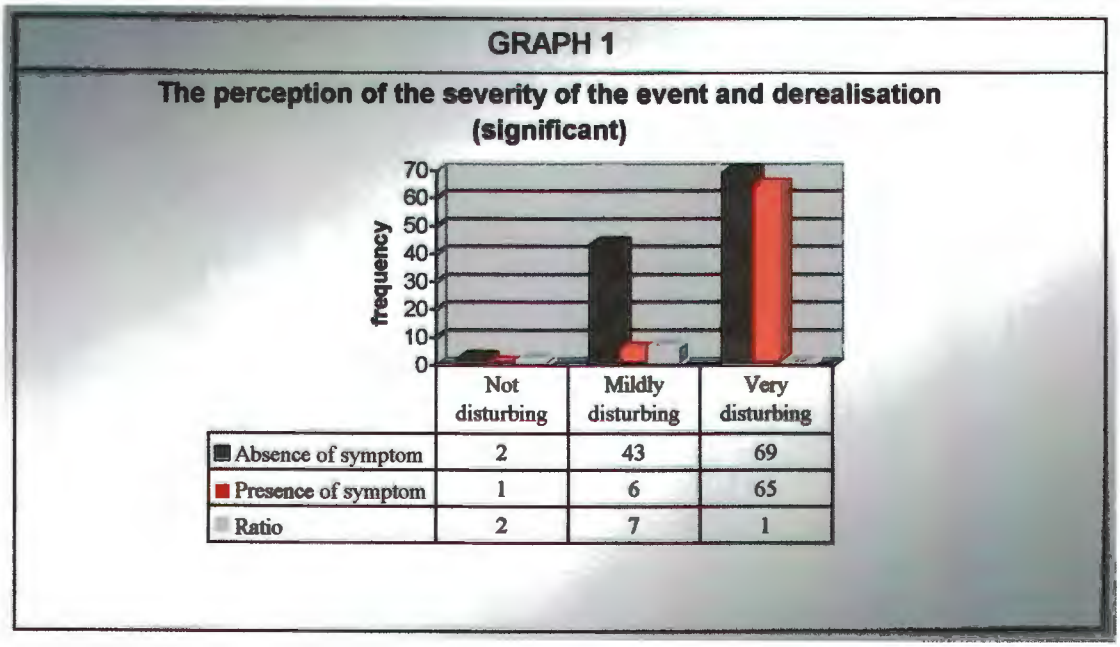
  No relevant significance at the 0.05 (95%) level of significance was found in most variables for depression, only a significant trend difference is indicated for gender (0.05).

4.4.1.2 *Summary of significant findings from frequency tables and associated chi-square and trend-test results*

From these findings it can be concluded that the respondents perception of the severity of the event and his/her gender has a highly significant affect on emotional symptoms experienced. Furthermore age has a significant impact on the vulnerability of the victim, age also has a significant affect on the experience of depersonalisation. A significant result and trend was found for the impairment in functioning for the victim and partner, while no significance in frequency distribution was found in the time lapse since the event and no significance in frequency distribution is indicated between the victim of an armed robbery or a carhijacking group.

4.4.1.3 *Graphs reflecting significant findings in table 4.6*

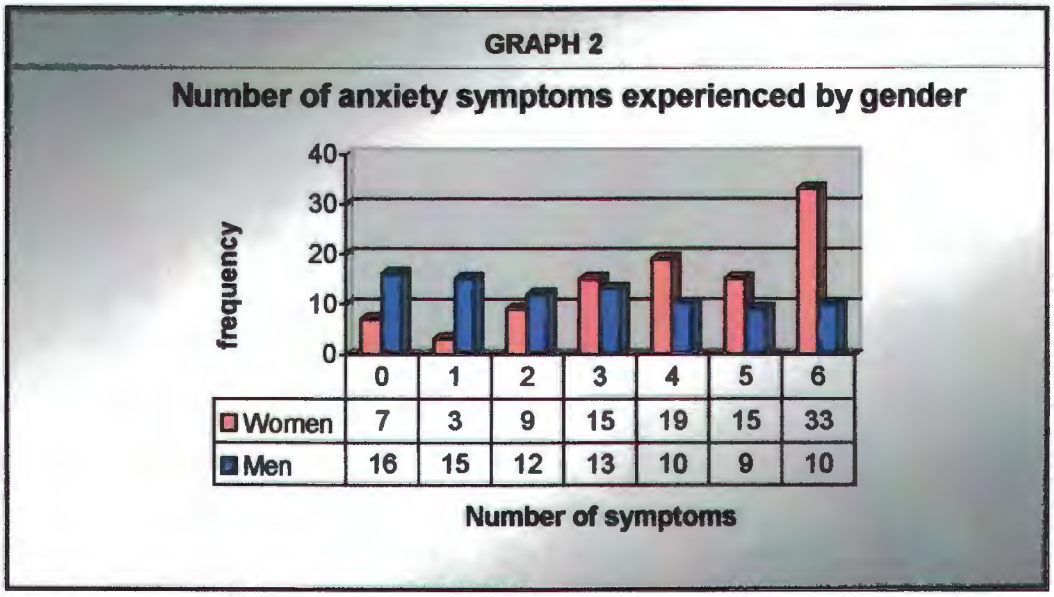
Severity of the event and derealisation. Refer to Table 4.6 for significance values and to the relevant frequency table, attached to graph 1.



Graph 1: indicates the significant effect of the perceived severity of the event (probability chi-square < 0,0004). When the traumatic event was experienced as "mildly disturbing", few victims and partners experienced derealisation symptoms (the ratio shows that for every 7 absent symptoms 1 symptom will be present), whereas when the event is experienced as "very disturbing", the occurrence of derealisation symptoms increased. In other words for every one symptom present one symptom will be absent (refer to section 3.5.2 for the method used to arrive at results reflected in the graph). Derealisation means feelings or perceptions of not being in touch with reality, people may seem unfamiliar or mechanical.

- **Gender as a variable that influences anxiety**

  Refer to Graph 2 and the attached frequency table for frequency ratios and Table 4.6 for significant values.

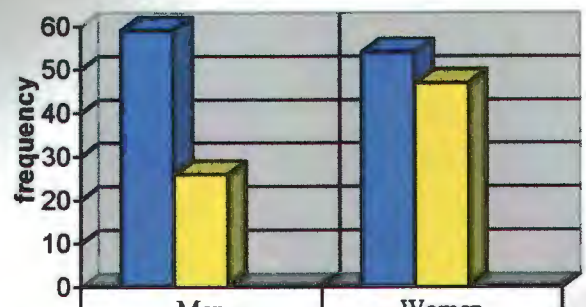


Graph 2: Since the trend test is applicable and significant in this instance (Probability Z: < 0,0001), the anxiety indicator *(as depicted in Graph 2)* suggests that men and women react differently when it comes to the number of anxiety symptoms experienced. Women tend to experience significantly more symptoms of anxiety and men less (refer to section 3.5.2 for method use to arrive at results reflected in the graph).

- **Acute stress disorder and gender:** Refer to Graph 3 and the attached frequency table for frequency ratios and Table 4.6 for significant values.

GRAPH 3

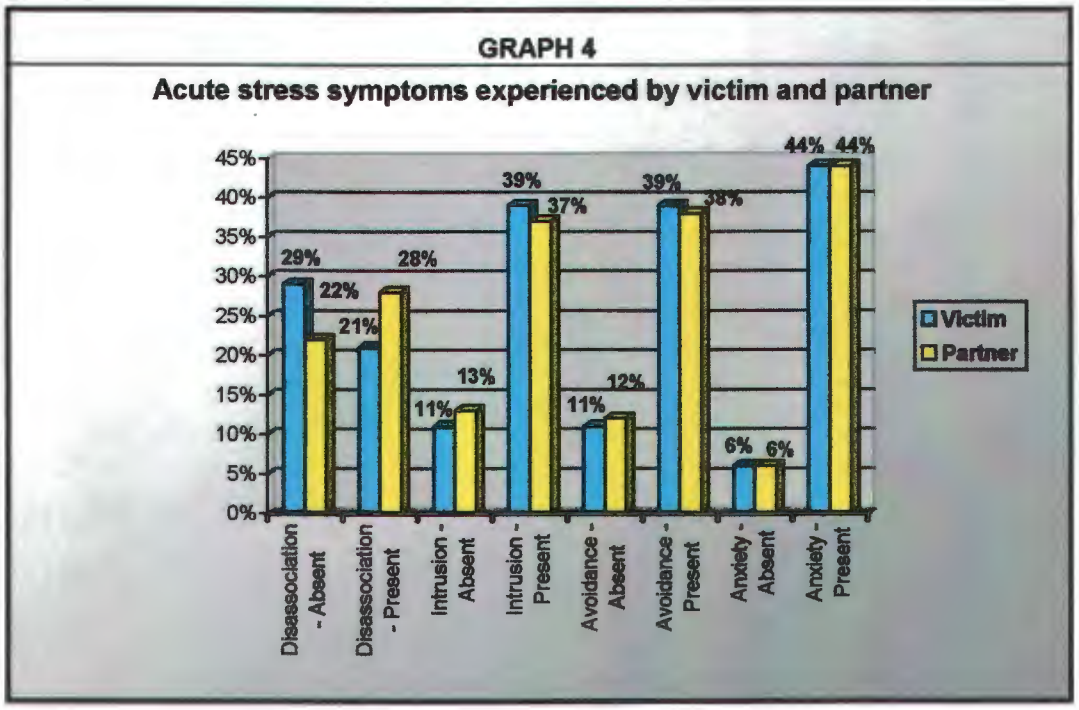
Acute stress disorder and gender (significant)



	Men	Women
Absence of Symptoms	59	54
Presence of Symptoms	26	47
Ratio	2.3	1.1

- **Graph 3** indicates the significant effect of gender on acute stress disorder (probability chi-square < 0,019). One can conclude from this graph that acute stress disorder is significantly less in men than in women. The ratio of absent to presence of symptoms for example indicates that the ratio for men is 2:3, whereas the same ratio for women is 1:1.

- **Comparison between acute stress disorder symptoms of the victim and the partner:** Refer to Graph 4 and the attached frequency table for frequency ratios and Table 4.6 for significant values.



Graph 4: Non-significant results are generally not discussed. However, in this study it is important to highlight it, if there is no marked difference between the reactions of primary and secondary victims. For this reason the non-significant results of the presence or absence of acute stress disorder symptoms are shown in bar Graph 4 from which the reader can see that the intensity of symptoms present in the primary victim is almost the same as in the secondary victim.

Consider anxiety and dissociation as examples (the presence of symptoms).

Graph 4 suggests that victim and partner show an equal presence of anxiety symptoms (44%). Of interest from graph 4 (although not significant) is that dissociation seems to be the only symptom experienced by the secondary victim that is higher than that experienced by the primary victim. Graph 4 clearly indicates that primary and secondary victims react in a similar way.

From the above results (Graphs 1-4) one can conclude the following:

1) The greater the severity of the event, the greater the derealisation experienced by the victim.

2) Anxiety and the presence and absence of acute stress symptoms resulting from the traumatic event are greater in the sample of women than in the sample of men.
3) There is no marked difference between the victim and partner's experience of acute stress disorder symptoms as a result of the traumatic event.

A paired-difference t-test was performed to substantiate the findings of the investigation into the effect of trauma on the victim and the partner.

4.4.2 **Step two: Paired-difference T-test comparison of victim and partner** Table 4.7.

A paired-difference T-test (parametric test) and a Wilcoxon Signed Rank test (non-parametric; usually small samples) were conducted on the differences between the victim's and the partner's emotional variables, the object being to establish whether the two groups acted similarly or not in terms of trauma, loss, vulnerability, acute stress and depression. These tests compare paired observations, for example, whether the emotional reactions of the victim and the partner to a traumatic event are similar or different.

4.4.2.1 ***An explanation of how to read the findings in Table 4.7 reflecting the summary of paired- difference test results:***

Table 4.7 gives a summary of the results from the t-test as well as the Wilcoxon Signed Rank test.

Table 4.7
Summary of paired-difference test comparison between victim and partner

	TEST 1		TEST 2		
Column 1 Emotional variables	**Students (t)**	**PROB (T)**	**Signed Rank (S)**	**PROB (S)**	**Interpretation**
Trauma difference	-0.03328	0.99735 > 0.05; ns	6	0.9784> 0.05; ns	Victim/Partner scores do not differ significantly.
Loss difference	0.2765	0.7828 > 0.05; ns	80	0.7279 > 0.05; ns	Victim/Partner scores do not differ significantly.
Vulnerability difference	0.0876	0.9304 > 0.05; ns	-104.5	0.6706> 0.05; ns	Victim/ Partner scores do not differ significantly.
Depression rating difference	-0.4696	0.6398 > 0.05; ns	-83.5	0.6911 > 0.05; ns	Victim/ Partner scores do not differ significantly.
Acute stress rating difference	-1,599	0.1133> 0.05; ns	-334	0.1323 > 0.05; ns	Victim/ Partner scores do not differ significantly.

Footnote: ns = non-significant (thus there is no significant difference between the victim and his/her partner as reflected in the questionnaires).

The results of the various pair-wise comparison tests as described in Chapter 3 (section 3.5.2.2) are summarised in **Table 4.7.** *Column 1* lists the five different emotional variables (such as trauma) on which the tests were performed. The column heading 'Test 1' refers to the parametric paired difference t-test for comparing paired groups. Student's t-statistic, T, and the probability associated with the t-statistic are given in the body of the table. The researcher wished to establish if the probability of the absolute value of the T-statistic for this test is more than 0.05, as it implies that the means of the two groups (partners and victims) do not differ significantly with regard to the emotional variable being analysed.

Likewise the column heading 'Test 2' refers to the similar, but somewhat more robust non-parametric Wilcoxon Signed Rank Test. If the probability value associated with the absolute value of the signed rank statistic, S, is more than 0.05, then the result is interpreted as indicating that the mean values of the two groups do not differ significantly. A probability greater than 0.05 would imply no difference between groups on both tests (If Probability (|T|) or Probability (|S|) < 0.05; then significant). So then Test 1 and Test 2 results of no significance is indicated in the table below, the result is noted in the "interpretation column".

4.4.2.2 *Summary of significant findings from Paired-difference t-test comparison of victim and partner*

There was no significant difference between the score-differences of the partner and victim on any of the five trauma indicators, namely, trauma, loss, vulnerability, depression and acute stress disorder, (probability >0.05) in every instance for both tests. These findings indicate that there is no difference between the ratings for partner and victim in the different emotions (for example, for trauma the probability associated with both the parametric and non-parametric tests are 0.99735 and 0.9784,column 2 and column 5 respectively).

From this table it is clear that victim and partner react in a similar way. A t-probability value > 0.05 indicates to the alternative hypothesis that the secondary and primary victims have very similar experiences of a traumatic event. The test therefore supports previous

statistical analyses that indicate that partner and victim react similarly for emotional variables. This has been the focus of the study and the paired-difference test adds further strength to the hypothesis of few differences in reactions to crime-related trauma between the victim and his/her partner. It is evident from results reflected in the frequency and chi-squared tables and the pair-wise difference test that victim and partner react in a similar way. The researcher now explored through Analyses of Variance whether age, gender and other biographical variables affect trauma scores, this was completed in order to ascertain where differences lie between victim and partner.

4.4.3 Step three: summary of analyses of variance results

"This is a form of data analysis in which the variance of a dependent variable is examined for the whole sample and for separate subgroups created on the basis of some independent variable" (Rubin & Babbie 1993:695). The dependent variables are depression, vulnerability, trauma, loss and acute stress while age, gender, qualifications, perception of the event, victim and partner are the independent variables. This information will tell the reader whether different age groups, for example, react differently to trauma. A summary of the results of the 35 analyses of variance's that were performed on the different emotional variables for different classifications are given in Table 4.8. One-way analyses of variance as well as the Bonferroni multiple comparison of means tests were conducted to see whether means for the most important biographical factors (like age, gender, and the severity of the event) differ significantly with respect to the different emotional scores obtained.

In chapter three section (3.5.2.3) a description is given of the analysis of variance technique and associated hypotheses.

4.4.3.1 *An explanation of how to read the findings in Table 4.8 reflecting the analyses of variance results*

Table 4.8 gives a summary of the analyses of variance.

KEY:

***	=	<0.001	(Very highly significant - Blue)
**	=	<0.01	(Highly significant - Yellow)
*	=	<0.05	(Significant - Green)

T-score = Trauma

V-score = Vulnerability

L-score = Loss

D-score = Depression

A-score = Acute stress score.

Table 4.8

Summary for analyses of variance -: combinations of emotional variables calculated and biographical classifiers on victims

COLUMN 1 Biographical (classification) variable	COLUMN 2 Emotional variable (score)	COLUMN 3 F probability (Fprob<0.05 Significant)	COLUMN 4 Means and (standard deviation)			
			Victim	**Partner**		
Victim and Partner Graph 5	T-score	0.97 ns	15,60 (8,61)	15,56 (8,44)		
	V-score	0.94 ns	12,11 (4,63)	12,17 (5,09)		
	L-score	0.84 ns	10,36 (7,59)	10,58 (7,39)		
	D-sum	0.76 ns	8,45 (10,02)	8,01 (9,16)		
	A-score	0.2066 ns	13.05 (8,78)	11.41 (8,81)		
			Female	**Male**		
Gender Graph 8	T-score	0.0002***	17.68 (8,41)	13.09 (7,95)		
	V-score	<0.0001***	13.61 (4,85)	10.4 (4,25)		
	L-score	0.0004***	12.22 (7,41)	8.38 (7,01)		
	D-sum	0.027*	6.53 (8.63)	9.64 (10.12)		
	A-score	0.0003***	14.39 (8.6)	9.733 (8.5)		
			18–29	**30 – 39**	**40 – 49**	**50+**
Age in years Graph 7	T-score	0.03*	14.16 (7.42)	17.26 (8.91)	16.93 (8.76)	12.90 (7.82)
	V-score	0.002**	11.05 (4.57)	13.44 (4.8)	13 (4.82)	10.26 (5.38)
	L-score	0.055 ns	9.62 (6.37)	11.57 (7.98)	11.86 (7.78)	8.11 (6.75)
	D-sum	0.054 ns	8.05 (7.32)	10.41 (11.41)	8.18 (10.05)	5.16 (5.93)
	A-score	0.163	11.51 (8.88)	12.34 (9.39)	14.50 (8.23)	10.33 (8.41)
			Pre-matric	**Matric**	**Graduate**	**Post-graduate**
Qualifications	T-score	0.661 ns	16,31 (9,57)	16,03 (8,43)	15,18 (8,34)	13,89 (8,13)
	V-score	0.907 ns	12,31 (5,61)	12,33 (4,65)	11,66 (4,83)	12,04 (5,03)
	L-score	0.634 ns	11,85 (7,70)	10,48 (7,95)	10,45 (6,61)	9,15 (6,74)
	D-sum	0.673 ns	8,23 (10,86)	8,98 (10,42)	7,55 (7,55)	6,59 (7,81)
	A-score	0.89 ns	13,38 (8,08)	12,05 (9,42)	12,32 (7,68)	11,67 (9,09)

			Not disturbing		Mildly disturbing		Very disturbing		
Severity of the event "How disturbing" Graph 6	T-score	< 0.0001***	10,33	(7,09)	11,41	(7,15)	17,23	(8,46)	
	V-score	0.053 ns	11,33	(7,09)	10,73	(4,33)	12,68	(4,92)	
	L-score	0.0008***	7,00	(5,00)	7,20	(6,31)	11,74	(7,55)	
	D-sum	0.096 ns	5,67	(4,51)	5,77	(7,75)	9,17	(10,11)	
	A-score	<0.0001***	5.33	(5.03)	7.16	(7.88)	14.24	(8.39)	
			White		**Black**		**Indian**		
Race	T-score	0.16 ns	15,01	(8,57)	17,97	(7,87)	18,75	(8,62)	
	V-score	0.32 ns	12,09	(4,93)	11,94	(4,39)	15,75	(5,12)	
	L-score	0.02*	9,74	(7,59)	13,81	(6,06)	12,25	(6,55)	
	D-sum	0.23 ns	7,74	(9,71)	9,81	(8,59)	14,50	(10,91)	
	A-score	0.001***	11,09	(8,71)	17,06	(7,90)	18,25	(3,60)	
			Hijacked		**Armed robbery**		**Both**		**Never experienced directly**
What happened	T-score	0.5995 ns	15,02	(8,84)	14,67	(7,61)	17,06	(8,77)	16,09 (8,71)
	V-score	0.3634 ns	11,93	(4,90)	11,35	(4,14)	13,35	(4,99)	12,30 (5,22)
	L-score	0.3984 ns	9,55	(7,21)	9,98	(6,76)	12,23	(8,66)	10,89 (7,55)
	D-sum	0.9010 ns	7,50	(9,39)	8,90	(8,39)	8,45	(10,55)	8,42 (10,26)
	A-score	0.49 ns	12.58	(9.19)	11.07	(8.44)	14.09	(8.33)	11.67 (8.94)
			<3 months		**3-6 Months**		**7-12 Months**		**12 months +**
Time-lapse	T-score	0.429 ns	16.37	(7.9)	16.88	(8.8)	12.88	(7.4)	15.32 (8.8)
	V-score	0.627 ns	12.0	(4.4)	12.5	(4.5)	10.7	(3.7)	12.3 (5.3)
	L-score	0.494 ns	10.7	(6.4)	11.2	(8.3)	7.8	(5.6)	10.6 (7.8)
	D-sum	0.401 ns	7.8	(9.9)	9.6	(8.2)	4.8	(4.7)	8.5 (10.4)
	A-score	0.639 ns	12.2	(7.7)	11.5	(9.5)	10.0	(8.9)	12.8 (9.0)
			Once		**Twice**		**Three +**		
How often	T-score	0.0001***	14.6	(8.5)	15.7	(7.1)	21.3	(7.7)	
	V-score	0.0003***	17.4	(4.8)	13.1	(3.7)	15.5	(4.8)	
	L-score	0.009***	9.9	(7.3)	9.5	(6.7)	14.8	(8.1)	
	D-sum	0.004***	7.5	(9.6)	6.4	(6.98)	14.2	(10.1)	
	A-score	0.264 ns	11.73	(8.97)	12.4	(8.05)	14.91	(8.43)	

Column 1 indicates the independent biographical classification variable. The effect of this biographical classifier on the emotional variable in *Column 2* is then evaluated. For example, the effect of different age groups (the biographical classifier) on emotional scores can be investigated to establish whether different age groups experience the same kind of trauma in different ways. If this were the case the mean trauma scores for the different age groups would differ significantly. The significance is indicated in *Column 3*. Each row entry in the table refers to the results of a specific analysis of variance. Column 2 indicates the emotional variable being analysed, which is the dependent variable referred to by Rubin and Babbie (1993:695).

The probability of the particular F-statistic calculated in the analysis of variance is listed in Column 3. An F-probability of less than 0,05 will indicate significant differences between the means of the variables under investigation for the specific biographical classifier. This implies that the classifier has a significant effect on the particular emotional variable. For example the biographical classifier of how often the event occurred has a significant effect on the trauma score (T-score). Means and standard deviations for each analysis of variance are listed in *Column 4.* These scores indicate averages and tell the reader by how far the scores deviate from the midpoint. For example, look at row 1 in the table(variable victim and partner): the mean (average score) for victim and partner in trauma (T-score) is 15,60 and 15,57 respectively. The standard deviation (of 8,61 and 8,44) gives an indication of the range above or below the mean where 68% of the scores will fall.

What follows is a detailed explanation of the *significance* in the findings of each analysis per row:

- *Row 1, victim and partner:*

  For the five trauma-related variables, namely trauma (T-score) vulnerability (V-score) loss (L-score), depression (D-score) or acute stress (A-score), indicated in column 2, no significant mean differences regarding partner/victim are indicated (probabilities of respectively 0.97, 0.94, 0.84, 0.76, 0.21 in column 3 refer).
- *Row 2, gender:*

  Very highly significant mean differences regarding gender are indicated for trauma, vulnerability, loss and acute stress scores (0.0002; <0.0001; 0.0004 and 0.0003 respectively, column 3). Significant mean differences regarding gender are indicated for depression scores (0.027, column 3).
- *Row 3, age:*

  Highly significant mean differences regarding age are indicated for vulnerability scores (0.002; column 3). A significant mean difference regarding age is indicated for trauma but not for loss and depression scores (0.03; 0.055; 0.054,respectively, column 3).

- *Row 4, qualifications:*

  Non-significant mean differences regarding qualifications are indicated for trauma, vulnerability, loss, depression scores and acute stress disorder (0.661; 0.907; 0.634; 0.673; 0.890; 0,163 respectively, column 3)

- *Row 5, perceived severity of event:*

  Very highly significant mean differences regarding perceived severity are indicated for trauma, loss, and acute stress scores (<0.0001; 0.0008; <0.0001 respectively, column 3). Non-significant mean score differences regarding perceived severity of event was indicated for vulnerability scores (0.053; column 3). Depression scores do not differ significantly with regard to perceived severity of event.

- *Row 6, race:*

  Highly significant mean score differences regarding race was indicated for acute stress (0.001, column 3). Significant mean score differences regarding race was indicated for loss (0.02, column 3). Non-significant mean score differences were indicated for trauma, vulnerability and depression scores (0.16; 0.32; 0.23 respectively, column 3).

- *Row 7, what happened and time lapse:*

  From the relevant entries in column 3, it can be deduced that non-significant mean differences for any of the score-variables regarding any of the abovementioned two classifiers were not significant (refer to column 3).

- *Row 8, how often:*

  Very highly significant mean differences regarding how often crime had been experienced by the respondents were recorded for trauma, vulnerability loss and depression (0.0001; 0.0003; 0.009; and 0.004, column 4). Non-significant mean differences in this regard were recorded for acute stress (0.264, column 3).

4.4.3.2 *Summary of findings from the analyses of variance*

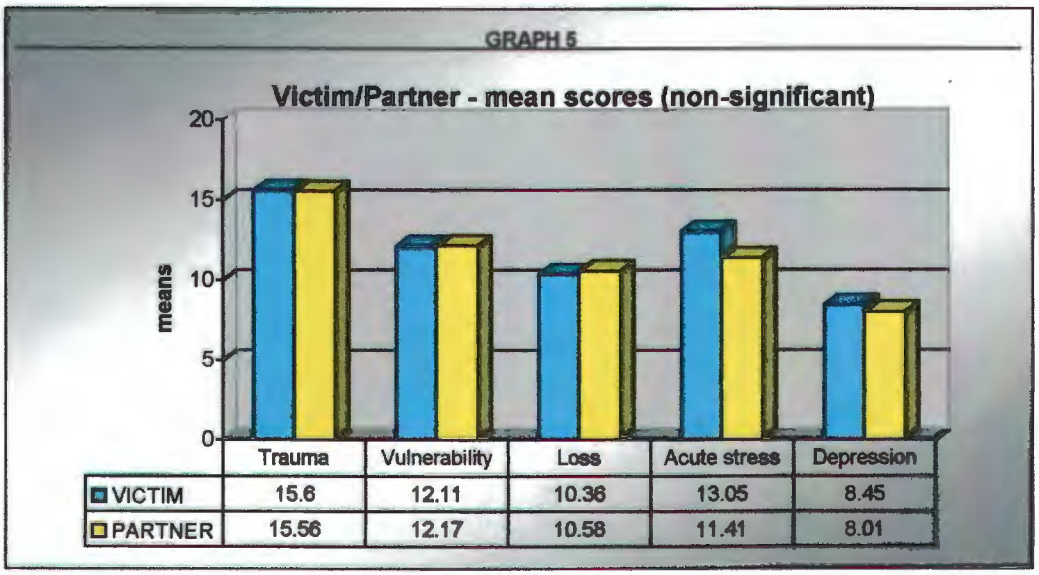
Mean ANOVA scores for each of the sub-tests/scales show that the trauma experienced by the victim is close to that of the partner. For example, the victim's mean score is 15,60 while the partner's mean score is 15,57. Thus, non-significant difference between the victim and the partner is evident from the effect on the scores for trauma, depression, vulnerability, acute stress and loss, as can be observed from the table. The same applies for the time factor ("time lapse"). There is a significant and highly significant difference

in the trauma and vulnerability scores for the different age groups. Age therefore appears to influence the way in which trauma and vulnerability are experienced and reacted to. Again there is a highly significant difference in the trauma, vulnerability, loss, and acute stress scores for the different genders. Accordingly gender appears to influence these scores. Race has a highly significant affect on the experience of acute stress. In the same way the person's perception of how disturbing the event was, influences his/her trauma, loss and acute stress scores. It is evident from this table that there is a highly significant correlation between the number of incidents of crime and the experience of trauma, vulnerability, loss, and depression. Non-significant differences in the experience of the trauma are apparent for the level of qualification.

Significant findings with regard to perception of the severity of the event, age and gender from table 4.8 are illustrated in graphs 6-8. Despite the fact that non-significant results are usually not discussed further, such results are indicated in graph 5, the reason being that Graph 5 relates to the important partner/victim aspect of this study. The mean scores for the different biographical classifiers from the various ANOVAs, are represented by the height of the bars.

4.4.3.3 *Graphs related to findings in table 4.8*

- **Bar Graph 5 provide comparisons between victim and partner**



Graph 5, backed by non-significance in the relevant analysis of variance Table 4.8 shows that secondary and primary victims experience a similar amount of trauma, once again

substantiating the hypothesis that after a traumatic incident the partner as secondary victim experiences trauma, acute stress, loss, vulnerability and depression in a similar way as the primary victim. In fact the significance of the extremely close relationship reflected in Bar Graph 5 between the secondary and the primary victim is sufficient to justify this research. Besides acute stress (where there is a non-significant difference of 1.64 points) there is not even a 1-point difference between the victim and the partner in the variables of trauma (0.04), vulnerability (0.06), loss (0.22) and depression (0.44). The graph illustrates that most victims experience mild or no depression (0-9 = no depression). No significant difference was found between the depression levels of the primary and secondary victims. The secondary victim shows a higher, although not significant, loss and vulnerability score. It is hypothesised that the reason for the partner's higher vulnerability score is the intensity of the primary victims' focus on themselves, rather than on the secondary victim, as a result of the physical, emotional and mental (cognitive) changes forced upon them by their traumatic experience. Meanwhile, the secondary victim becomes not only concerned for their loved one, but there is a confirmation of his/her own vulnerability (see section 2.10). S/he in turn becomes more introspective as a result of an internalised awareness of his/her own as well as his/her partner's mortality (Parson 1998:245). It is evident from the pair-wise difference t-test and the ANOVAS (presented in Table 4.8 and Graph 5) that primary and secondary victims react in a similar way.

Since no difference between the victim and partners' reaction to trauma was found the researcher became interested in the combined group of primary and secondary victims as representative of the sample population and how they differ in their reaction to trauma.

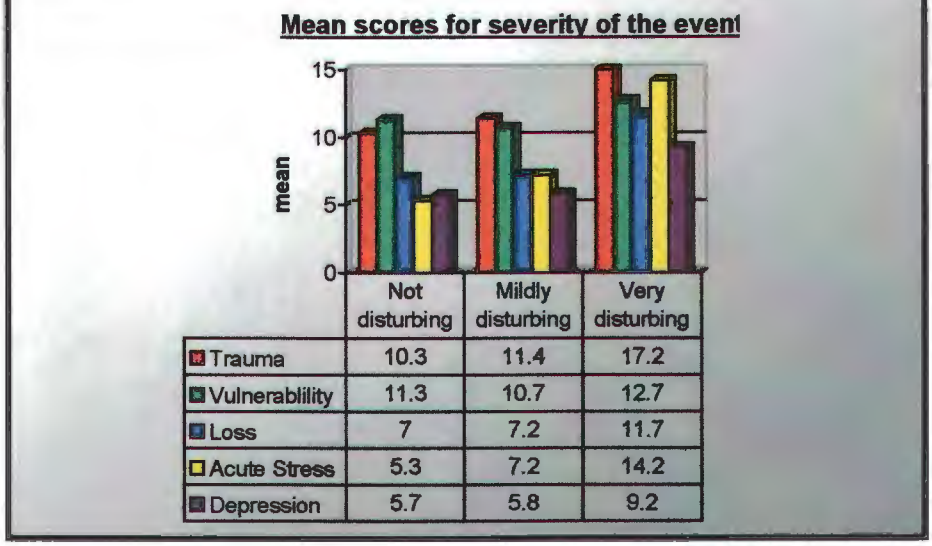
Age, gender and the severity of the event, were singled out to be displayed graphically. Schillace (1994) and Dyregrov (1992:193) provide the reasons for this. Schillace, the developer of one of the questionnaires (Schillace Scales) used in this study, contends that age and gender are two factors that must be taken into consideration in attempts to understand reactions to traumatic events. Dyregrov (1992:193) explains that the victim's interpretation of the severity of the event will influence their reactions. **Graphs 6-8** provide comparisons between how the respondents react to trauma, vulnerability, loss,

acute stress and depression in terms of: the severity of the event, age, gender and the trauma levels experienced in the victim and the partner.

- **Mean scores for severity of the event-Graph 6**

The following Graph will indicate that mean scores increase as the level of severity of the experience increases. Like previous statistical data (derealisation and severity of the event), this graph provides further evidence to the effect that the more severe the perception of trauma, the greater the negative impact on the victim and his/her partner in terms of trauma, vulnerability, loss, acute stress and depression.

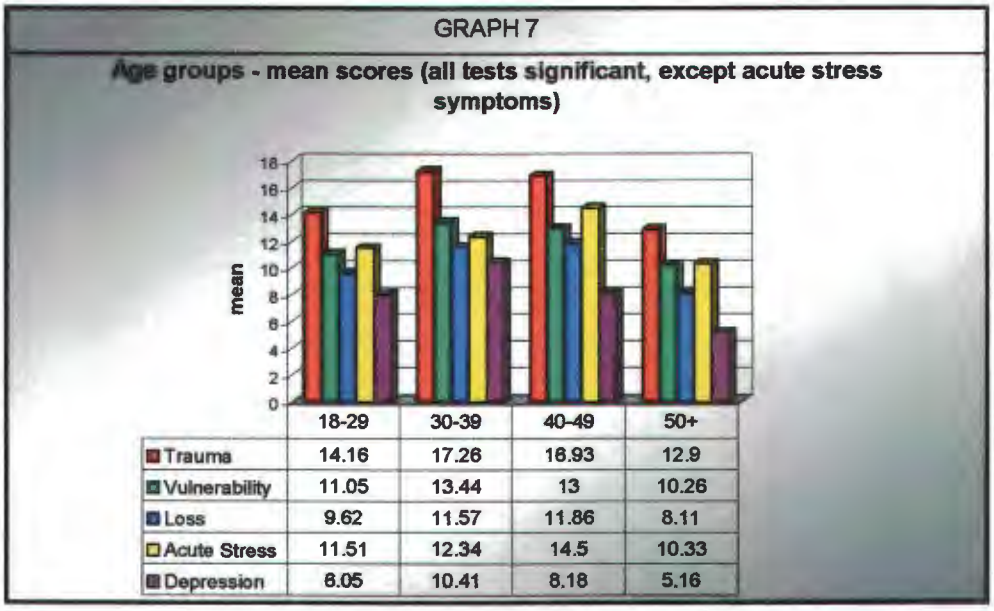
GRAPH 6



- **The mean scores for age are reflected in Graph 7:**

From the significant results in **Table 4.8** and the following graphic display (Graph 7), it is evident that the oldest group (50+years) have the lowest means throughout the tests, differing significantly from the other age groups in each instance (this was tested with the Bonferroni multiple-means test). It is possible that due to them being older they have more life experience or coping strategies to deal with the factors tested. The reasons for this difference are not clear and require further investigation in future research.

GRAPH 7



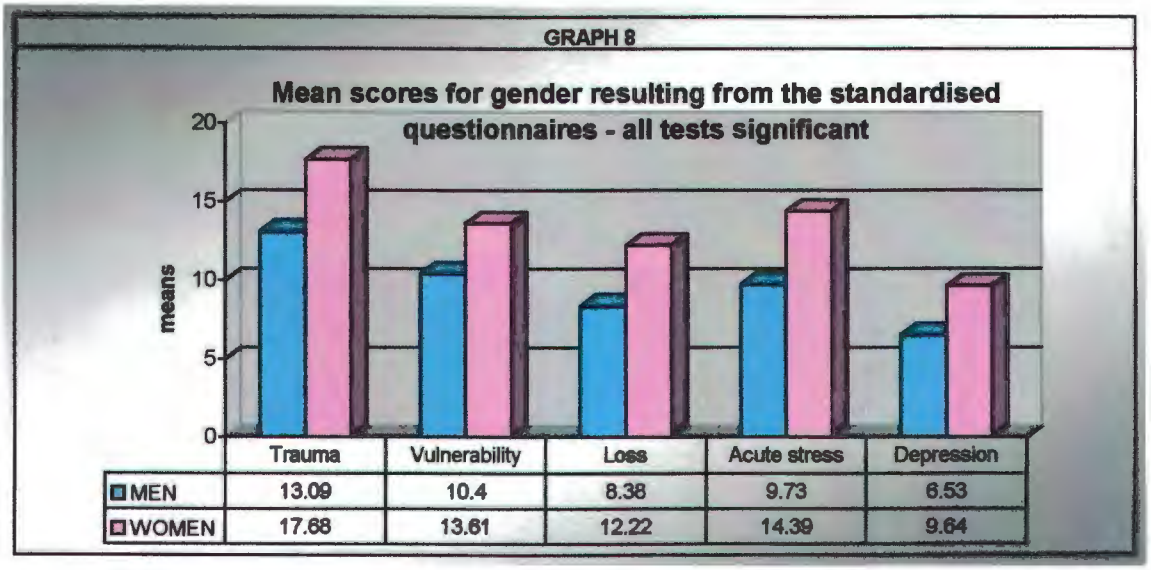
	18-29	30-39	40-49	50+
Trauma	14.16	17.26	16.93	12.9
Vulnerability	11.05	13.44	13	10.26
Loss	9.62	11.57	11.86	8.11
Acute Stress	11.51	12.34	14.5	10.33
Depression	8.05	10.41	8.18	5.16

Of note for the age group 30-39 is what Schopenauer says (in Santrock1995:464): "Middle adulthood is often a foggy period of life, a time to discover what one is running to and from and why". According to Victor Frankl middle adulthood is characterised by man's search for meaning. The uncertainties referred to by Frankl and Schopenauer may have a bearing on this age group's response to the traumatic experience of becoming a victim of violent crime in that it may contribute to the victim's sense of meaninglessness after the event.

Though not significant the 40-49 age group seem to experience higher acute stress than the other age groups. The youngest age group appear to be the second least affected (50 + group least affected) by the traumatic crime-related incident. This is the period of early adulthood when careers and relationships are mostly formed and stabilised. It is speculated for this study that this group has the best recovery rate because relationships are usually at their strongest in terms of emotional support at this stage of development (Santrock 1995:453).

- **The mean scores for gender are reflected in Graph 8**

Graph 8 is based on ANOVA Table 4.8. Significant differences in mean scores results are reflected in Graph 8, which is derived from ANOVA Table 4.8.



Perhaps one could ascribe these lower scores of the male gender to the fact that boys/men are taught to conceal their weaknesses - "cowboys don't cry". Zlotnick (1997:90) claims that South African men are "notoriously reticent about voicing any vulnerability they may feel. But as more and more men become victims of violent attack, they are being forced to address this emotional response". This masculine bravado or fearless facade can trigger a reactive aggression against the self (the denial of one's own vulnerability) and others in the display of verbal and other forms of aggression. Anger seems to be a "permissible" emotion experienced by victims of crime-related trauma (Garland 1998:81). On the other hand, fear and vulnerability may invite shame, so "men" must "pull themselves together, to prevent shame".

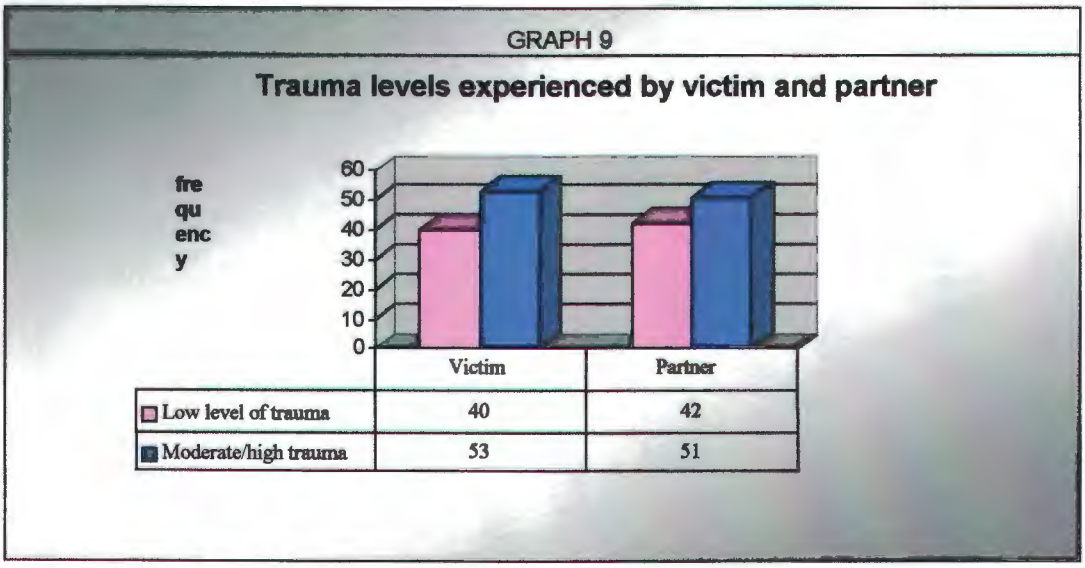
- **Masked Studies**

As found in so many studies (Peterson 1993:196 & Dempsey *et al* 1999:155) over the years, the effect of gender has also emerged strongly in this study, this was substantiated by the significant gender effect in the various analyses of variance results. Since one knows the effect of gender can mask other effects in a study - *the question was raised: could findings in this study be masked by gender*? Landau (1997:51) purports that "the most cardinal division in society is gender. Valuable information is masked by studies in which no differentiation is made along the gender variable". Results in the study have indicated that the sample of primary victims shows a similar pattern to the sample of secondary victims, but within each sample a notable difference is reflected in the gender variable, but the gender effect is still similar for partner and victim. This is illustrated in the following trauma levels assessment score. A frequency table and chi-square statistic

on the trauma levels for victim and partner do not show significant differences in the proportions between the trauma levels of partner and victim (Probability (chi-square) = 0. 077). **Graph 9** illustrates that partner and victim do not react differently to trauma. In proportion both partner and victim experience more "moderate to high" than "low" trauma levels.

4.4.3.4 *Trauma levels experienced by the victim and the partner*

GRAPH 9



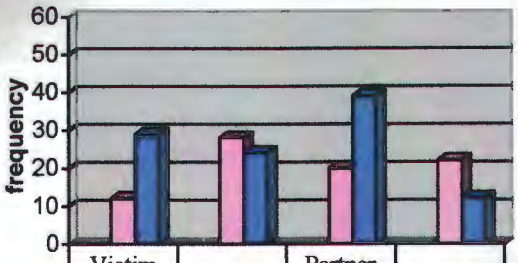
The effect of gender becomes clear if it is borne in mind that the victim could be either male or female, and that the same applies to the partner when the above-mentioned trauma scores are subdivided for gender. The trauma level proportions between male and female differ significantly within the victim subgroup (probability (chi-square) = 0.0175), which means that in proportion female victims experience higher trauma levels than males. The same significance holds for the partner subgroup (probability (chi-square) = 0.0004).

4.4.3.5 *The effect of gender on the victim and the partner*

In accordance with the rest of the findings in the study, the two subgroups, victim and partner, follow the same pattern within their subgroup, with women experiencing trauma more intently and then, looking at the broader picture (Graph 9) victim and partner react similarly to the traumatic event.

GRAPH 10

Trauma levels experienced by victim and partner and the influencing variable of gender



	Victim		Partner	
	Female	Male	Female	Male
Low level of trauma	12	28	20	22
Moderate/high trauma	29	24	39	12

Therefore, the hypothesis stated in chapter one (section 1.8.1) is accepted: primary and secondary victims experience similar trauma patterns after exposure to a crime-related violent incident, but men do not experience the trauma to the same degree or intensity as women. Gender-related differences regarding derealisation and perception of the severity of the event was found. There will be a difference between the way different age groups react to the traumatic event, with those in middle adulthood experiencing the highest degree of trauma. The oldest age group will experience the lowest levels of trauma.

This being true, the final task was to establish if emotional variables were related: a regression analysis establishes this.

4.4.4 Step four: linear regression result

4.4.4.1 *An explanation of how to read the summary of simple linear regressions between emotional variables as found in table 4.9:*

A summary of the results of simple linear regressions (as discussed in section 3.5.2.4) between pairs of emotional variables is given in the **Table 4.9** to provide an indication of the relationship between the scores.

Table 4.9 ***Regression analyses***			
COLUMN 1 Dependent Variable (emotional)	**COLUMN 2 Independent variable**	**COLUMN 3 Pr (F) significant**	**COLUMN 4 R Sq**
Trauma score	Loss score	<0.0001	0.73
Trauma score	Vulnerability score	<0.0001	0.65
Trauma score	Depression score	<0.0001	0.54
Loss score	Depression score	<0.0001	0.57
Loss score	Vulnerability score	<0.0001	0.47
Trauma score	Acute score	<0.0001	0.46
Vulnerability	Acute score	<0.0001	0.30
Depression	Acute score	<0.0001	0.28
Loss	Acute score	<0.0001	0.51

Each row entry in the body of the table represents a regression analysis of the relationship between two specified emotional variables, for example loss against trauma. *Column 1* indicates the particular dependent variable (or y-axis), and *Column 2* indicates the independent variable (or x-axis) in the regression. *Column 3* indicates the probability of the F-statistic associated with the regression. A probability of less than 0,05 will indicate that the regression (relationship) between the two variables is significant. This implies that there is a significant relationship between the two variables mentioned in Columns 1 and 2. *Column 4* lists the R-square value for the particular regression. The R-square values indicate how well the data fit the model. These values can vary between 0 and 1, and a value close to one will indicate a good fit. In other words, the independent variable explains much of the variation in the dependent variable.

Most of the scores indicate a relatively good fit. This means that a reasonable relation exists between the above dependent and independent variables with the exception of depression and acute stress (0.28).

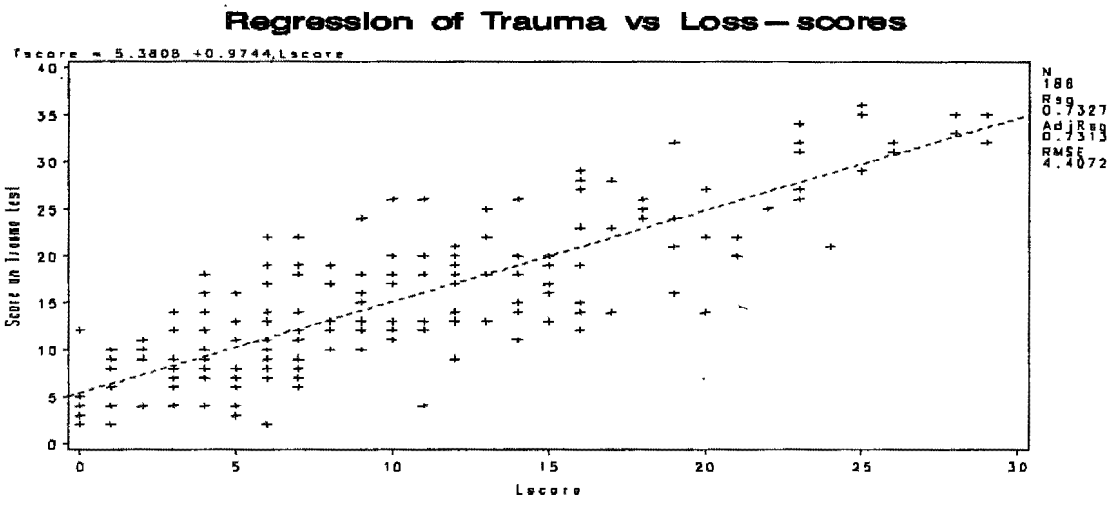
4.4.4.2 *Summary of results of regression between test scores*

An example of one of the above regression lines which follow, show that the different pairs of emotional score variables are all positively related – thus implying that a respondent with a high score for one score variable in a regression is likely to have a high rating on the

other score variable in the regression (e.g. high trauma score, high loss score; low trauma score, low loss score). Respondents are likely to have scores of the same order for the different score variables thus there is evidence of the integration, range and complexity of the various trauma experiences.

One traumatic experience can result in a combination of disruptive experiences and may interfere with general functioning. (Only one line graph - 11 is given for illustration).

4.4.4.3 *Graph related to findings in table 4.9*



4.5 QUALITATIVE RESULTS - OBSERVATIONS

Observations were taken from the debriefing sessions, informal telephonic interviews and the researcher's personal observations. These informal findings are briefly discussed in order to provide depth to the study. From observations besides those already discussed within the report of findings, the following should be noted:

- Many of the victims give the perpetrator of the event a name, such as "my guy" or "my oke". The explanation for this personalisation could be that the victim feels it is the only way for him/her to gain some control over the perpetrator.
- The researcher found the secondary victims on the whole more difficult to speak to and far more opposed to completing the questionnaire or meeting with and talking to the researcher than the primary victims. The resistance of the partners may be due to their apparent ability to contain their trauma. However, reluctance to talk about it may also be due to reluctance to accept that they (the partners) are also "victims" or

that they may feel that by talking about and acknowledging emotions they may be further traumatising the primary victim.

- Primary victims seemed particularly concerned that their respective partners had to take over many of their responsibilities during the recovery period and at the same time cope with their own emotional reactions to the event.
- The following comments emanating from debriefing sessions with primary and secondary victims are worth reporting:
    - " We live in a dead society."
    - " People are too tired to care, they just walk past."
    - "My chance has come now it is finally over, and at least I know how I react."

The perceived hopelessness of the victim's situation is apparent. Victims felt a hopelessness and helplessness that robbed them of the capacity to counter this aggressive crime. It was almost as if they regarded the violence they had suffered as an inevitable part of life in South Africa. People seem to dissociate from the violence in South Africa as a self-protective measure. Victim comments such as these are indicative of the continuous stress-related situation of the times in South Africa (Farber-fisher 1997:3 & Holford *et al* 1993:58).

In **Table 4.10** it was considered a useful categorisation of psychological traumatic-stress response patterns to divide them into three classes according to the cognitive, emotional and relational effects apparent from the literature study. In a similar fashion these effects/symptoms under the umbrella terms of trauma, loss, vulnerability, depression and acute stress symptoms were measured in chapter four and are summarised in Table 4.10 for completeness.

Table 4.10
Summary of the effects of trauma

Cognitive	Emotional	Relational
Intrusion	Anxiety	Loss of self-worth
Dissociation	Depression	Vulnerability
	Anger	Dissociation
Avoidance	Numbing	Withdrawal
	Arousal	Loss of intimacy

4.6 SUMMARY

This chapter reviewed the results of the three standardised questionnaires in order to determine how the victim's and his/her partner's experience of a traumatic incident differ. In addition it looked at other factors, such as age, time-lapse, what happened, gender and the severity of the event that could have affected the emotional variables. In the analysis the three questionnaires used to measure trauma were the - Schillace Scales, Stanford Acute Stress Reaction Questionnaire and the Beck Depression Inventory.

Overall this study has shown that the traumatic experience of the primary victim influences the level of trauma experienced by the secondary victim, but that men do not experience the trauma to the same degree of intensity as women. The results clearly indicate that the victim and the partner have a very similar experience of a crime-related traumatic event even if the partner did not witness the incident, but only heard about it. That is to say, although the partner experienced the traumatic event indirectly, the impact of the traumatic event appears to be just as severe. Whereas the focus of therapeutic intervention tends to be on victims, very little assistance is given to the partner. The results of this study reveal that the partner should receive equal assistance and understanding, in particular since the trauma caused by the event, seems to have an impact on the relationship with the primary victim, possibly ending in permanent separation.

Chapter 5 summarises the results of the entire study in terms of the objectives of this research as well as the findings of each chapter. It will go on to discuss the limitations of this study and make recommendations for future studies.

CHAPTER FIVE

IN CONCLUSION

Summary, recommendations and limitations

5.1 INTRODUCTION

Victor Frankl, a Nazi concentration camp survivor, maintains that "an abnormal reaction to an abnormal situation is normal behaviour." In the light of Frankl's statement it stands to reason, that educational psychologists have to determine whether a victim's reactions are normal or abnormal within the context of his/her traumatic experience, and it is not surprising that this is a difficult task. Normal and abnormal reactions to traumatic criminal events have been dealt with throughout this dissertation.

This chapter concludes the study. Initially an overview of the entire research study is given. This is followed by a summarised discussion of the findings of each chapter. Finally the limitations of the study are discussed and recommendations are made for future research.

5.2 OVERVIEW OF THE STUDY ON CRIME-RELATED TRAUMA

The introductory chapter provided a framework assessing why crime in South Africa has escalated. While attention has been given to helping primary victims, chapter one showed that secondary victims have been ignored. The research findings in chapter four contribute towards repairing this omission. In chapter two, attention was paid to literature, including the meaning, severity and history of trauma as well as the special role of the educational psychologist. Besides noting the findings of international literature pertaining to post-traumatic stress or acute stress in the primary victim, this chapter seeks to reveal the actual effects of the crime-related traumatic encounter on

South Africans, particularly as secondary victims. Chapter four presents the findings and experiences of primary and secondary victims.

5.2.1 Findings according to chapter one – introductory orientation

Since South Africa's transition eight years ago from white minority rule to democracy, the country has ridden a turbulent wave of change. Chapter 1 revealed how radical change has "affected", or as some would say "infected", many areas of life in this country (Finn & Gray 1992:50). Whether directly or indirectly, all South Africans have been touched at some point. It is in researching the indirect incidence of trauma that this study differs from others completed in South Africa. The researcher explores beyond the chaos experienced by the primary victim of the crime, to investigate the partner who is indirectly affected.

The literature showed how South Africa is faced with high trauma rates and disconcerting levels of crime against a background of educational deprivation, political upheaval, a strained economy and high unemployment levels. Rapid urbanisation together with illegal immigration is swelling the number of people living in informal settlements. These are just some of the factors mentioned which appeared to contribute to current crime rates in the country. The question was raised as to whether there is a connection between a previous experience of violence and presenting violent behaviour. In other words, does violence beget violence?

Chapter 1 proposed that the responsibility of the educational psychologist lies in addressing trauma, within the context of the family system and the environment of the victims of crime-related trauma. While "crisis intervention" is an accepted and effective part of the educational psychologist's therapeutic repertoire for helping people respond to trauma, attention has not focused on the secondary victim, something which the findings of this research demand.

5.2.2 Findings according to chapter two – literature review

In conducting a literature study pertaining to the research question, the work of the theorist Figley was consulted since he coined the term "secondary trauma". The study first provided the reader with an awareness of the history of trauma and the different types and severity of violence and trauma. The literature indicated that terrible events like criminal violence are very hard to deal with. Those who go through a catastrophic life experience, whether directly or indirectly, often feel permanently changed by the impact of what has happened. They become numb and shut off from those around them, or a sense of loss, vulnerability, depression, or anxiety may constantly weigh them down. Sometimes victims feel hypervigilant and on edge. Recollections of horrifying scenes from the incident may unexpectedly intrude during waking hours (flashbacks), while their sleep may be disturbed by vivid unpleasant memories. These feelings of "loss of control" can cause the victims to feel susceptible to harm – in turn affecting their feelings of self-efficacy.

Traumatic stress responses, including post-traumatic stress, acute stress and secondary traumatic stress are psychological conditions that result from a person's coping resources having been completely overwhelmed by a traumatic experience. The effects of flashbacks (intrusion) can be so severe that victims may feel they are losing their sanity, with the result that they become ever more secluded in their distress. *This is when the secondary victim becomes even more " infected".*

Literature shows how the needs of the secondary victim are in direct contrast to the difficulties being experienced by the primary victim. Besides those mentioned above, the primary victim's difficulties are: problems with intimacy, interpersonal relations and child-rearing, while the secondary victim's needs are for closeness, communication and a sense of predictability. Inherently, therefore, secondary exposure to trauma must have an impact on relationships. Figley (1995:131) reports that "trauma is situated in the relationship with the other". Personal relationships may suffer due to increased stress or difficulty with trust and intimacy (Allen 1995:8). It was assumed that the secondary victim would also experience similar distressing emotions, including sadness, a sense of

loss and vulnerability, depression, anxiety, fear, rage, experiences of intrusive imagery of the victim's traumatic experience, somatic complaints including sleep difficulty, headaches, gastrointestinal problems, heart palpitations, addictive or compulsive behaviours, and physiological arousal (vigilance). These experiences would impair his/her general functioning.

5.2.3 Findings according to chapter three – research methodology

The aims of the research determined which research design would prove to be most suitable. Qualitative and quantitative research methods were used. The order of method was: firstly, a telephone call asking if the victims and their partner would participate in the study. This was followed by a hand delivered questionnaire and finally a telephonic interview. Some victims were asked to participate in the study after an initial debriefing session.

The results are based upon data provided by 93 secondary victims and 93 primary victims who had experienced a crime-related traumatic incident. Responses to the questionnaires were hand scored and used along with biographical information and the SAS statistical package. Biographic information shows the representation of the group. One-way frequency tables were calculated for the biographic classifiers and emotional variables. The important question, whether the partner's and the victim's emotional reactions to a traumatic situation were similar or different, was addressed through the pair-wise analysis of differences between the means for the two groups. Since no differences were found, other biographical classifiers were investigated to determine if any of these variables could explain why different respondents exhibited different emotional responses to an event. This was the reason for the 35 analyses of variance where age, gender, race, income, type of crime experienced, qualifications, perception of the severity of the event and the time lapse since the occurrence of the event became the secondary focus. Another question posed by the study was whether there was a relationship between the dependent variable of trauma and the independent variables of vulnerability, loss and depression. A linear regression analysis indicates that such relationships do exist. This means that the emotional variable being measured increases in concert with trauma.

Information for this analysis was provided by the following measuring instruments: Schillace Scales, Stanford Acute Stress Reaction Questionnaire and the Beck Depression Inventory. Qualitative questions were asked on which biographic classifiers were collected for gender, age, income and methods of coping, whom the victim turned to for advice, psychosomatic symptoms and other types of trauma. Responses to the three scales were analysed for the variables of trauma, loss, vulnerability, depression, and acute stress symptoms, including avoidance, general impairment of functioning, dissociation, anxiety, intrusion and hyper-arousal.

Since all inventories were quantitative in nature and found to be valid and reliable, they were ideal for research purposes.

5.2.4 Findings according to chapter four – reflection of research results

In this chapter research attempted to redress the lack of serious attention hitherto given to the question: To what extent are the symptoms of the violent incident first experienced by the primary victim also found in the most intimate associate of the victim (the secondary victim)? Analysis of the effects in this investigation not only broadens our understanding of trauma patterns in the victim's partner, but also indicates that these results may have useful implications for the educational psychologist. As has been said, the sample assembled was essentially a convenience sample of 93 couples who had experienced a crime-related traumatic incident. All primary victims had been involved in a car hijacking or armed robbery, both crimes being referred to as robbery. Findings returned for both primary and secondary victims showed they react in a similar way to trauma, loss, depression, vulnerability and acute stress but that men do not experience the trauma to the same degree of intensity as women. Questionnaire results reflect relatively low mean scores for all of these indicators. This suggests that although the level of trauma may initially have been high (i.e. immediately after the event) the trauma levels subside markedly over time. It was evident that age and gender affected trauma levels where the 50+year and younger age group experienced lower stress levels, as did the men in the sample group. The experience of derealisation increased according to the severity of the event.

5.2.4.1 *The following findings emerged from this study:*

- The statistical analysis showed no significant difference between the victim and the partner. One can thus accept the hypothesis that no difference in the experience of trauma exists between the primary and secondary victims. This accords with the plea of Holford *et al* (1993:62) that it is becoming important for authorities to develop policies and practices to support the entire family after trauma.
- Using the Schillace Scales, Stanford Acute Stress Reaction Questionnaire and Beck's Depression Inventory as a reference, the data support the findings of similarities in responses of trauma, loss, vulnerability, acute stress and depression as post-traumatic states in both the partner and the victim.
- However the evidence from this study refutes the hypothesis that chronic symptoms of post-traumatic stress disorder or acute stress persist after trauma that involves a carhijacking or armed robbery. Although there certainly are traits of traumatic stress, the levels were lower than were expected among victims. Most notably, the results presented underscore the importance of post-traumatic stress as the only significant reaction to crime.
- The variable scaled differences across age groups support the hypothesis that age affects the magnitude of trauma, loss, vulnerability and acute stress response, with the period of middle adulthood (30-39 years) being the most affected. The oldest group (50+) were notably less affected.
- Gender affected the prevalence of symptoms of trauma. Very significant gender differences were found for the trauma scales with females receiving higher scores. This measurement is consistent with data of the Schillace Scales. The data showed that women reported a stronger state of emotional reaction to a violent traumatic incident (Schillace 1994).
- The similarity of performance on all scales does suggest a strong relationship between the victim and partner. These reactions seem to be highly related suggesting that the victim and partner experience the above emotional variables to a very similar extent. Literature revealed that if depression was not

prevalent in the early aftermath of trauma then post-traumatic stress was not likely to follow. This study confirms the reciprocal relation between depression and post-traumatic stress disorder; that is: one disorder does not appear to occur without the other.

- The secondary victim experiences higher levels of vulnerability and impairment in functioning than the primary victim as reflected in the acute stress scores. The findings lend support to Janoff-Bulman's theory suggesting that victimisation can exert a powerful influence on people by challenging their assumptions about the world as meaningful, safe and controllable. This shift in perception does result in some emotional distress, with a higher significance in the area of vulnerability. The meaningfulness that victims find according to this theory will in turn affect their level of functioning. The theorist Wertz (1985:197) concurs with this theory he said that if the world is not predictable then people become vulnerable and are not able to function.

5.2.4.2 *Qualitative observations*

What became most evident as the research progressed was that many of the victims who had experienced the violent traumatic incident had subsequently separated or divorced from one another. This important observation confirms Herbert's (1999:32) comment that marriage and partnerships could break up or become alienated after trauma. According to psychoanalytic theory this could mean that some underlying aggression existed prior to the event. Trauma theory teaches that past emotions (traumas) are given fresh life with new events. Thus past emotional trauma can lead to aggression which leads to conflict within the marriage, which can in turn lead to a break-up of the marriage or partnership.

Considering the above impact of trauma on relationships, it was noted with some concern how many victims do not acknowledge that they need help. Yet when the researcher went to collect the completed questionnaires many of the respondents came out armed, stating: "You just don't know when you can be attacked". Other victims

comment that they became very pensive or obsessional, the latter of which is an attempt, according to Freud, to process intense emotions (Garland 1998:13).

5.2.4.3 *The following findings are consistent with those of other studies*

Traumatic events undermine victims' beliefs about themselves with the result that they experience a sense of loss of control. The findings confirm those of Peterson (1993:196) who refers to, Figley (1978), Stanton (1975) and Williams (1985), namely that wives of war veterans experienced problems like feeling overwhelmed at becoming the emotional support for the family and became frustrated at their inability to help (section 2.10). It is assumed that this feeling of helplessness is one of the reasons for the post-traumatic communication problems noted by Peterson (1993:96). It also partly explains the apparent changes in relationships as noted in this study. Kusher's "chiasmal effect"(a term referring to the "crossing over" of symptoms of trauma from the victim to their supporter) is certainly very evident in the strong similarity in findings between the primary victim and the partner.

5.2.4.4 *The following findings of the study are in contrast to others*

The study did not support the findings of Davis *et al* (1996:32) that victims from lower socio-economic groups are more traumatised by crime than other groups. On the contrary, it found that trauma reached particularly high levels in the higher income group. The other difference that this study holds is that where Schillace found the 50-year olds to be more affected by a traumatic event, this study found them to be the least affected. Studies by Roe-Burning *et al* (1997:325) found that direct exposure to trauma affects the individual's sense of invulnerability more than does indirect exposure. However the present study found a slightly higher but not significant sense of vulnerability in the partner after indirect exposure to a traumatic incident. Exposure to criminal violence was therefore associated with the partner's sense of invulnerability. Many researchers have documented that post-traumatic stress disorder is a frequent diagnosis after a traumatic event but Kamphuis *et al* (1998:200) questioned if the diagnosis was accurate after crime-related trauma, as it had only been tested on war and

disaster victims this study found that symptoms of post-traumatic stress were indeed present in victims of crime.

The significance of these contrasting findings to findings in this study bears some comment. The current study, unlike others in the area, did not only investigate the primary victim but instead considered the impact on the secondary victim. It also examined a convenient sample of victims, who mostly did not go to clinics for therapy, but were sourced from churches, schools and sports clubs and by word of mouth.

Finally the researcher notes a few limitations that qualify the conclusions drawn from this data.

5.3 LIMITATIONS OF THE STUDY

In any area of research, limitations necessarily apply, particularly so in a new area of study. In the case of this specific research the following restrictions were noted:

- There is a lack of theoretical consistency in the field of trauma for the secondary victim. This means that it is difficult to justify or explain procedures and results based on theory and literature.
- The definition of the event and its interpretation are left to the individual and may vary, for example, a secondary victim of crime-related trauma may be anybody – from a spouse to a passerby to a therapist. According to literature all these "secondary" victims were traumatised through crime.
- Differentiation was not always made between whether the victim was male or female.
- Given the choice, the traumatised do not readily volunteer for assistance (Mitchell and Everley in Richards 2001:360). Even though many people have experienced traumatic incidents, accessibility to data was difficult and time consuming and many did not want to "open old wounds". It therefore became

difficult to generalise these findings due to the sample group not being proportionately representative of the population.

- It is difficult to conduct research on trauma, particularly when it is crime-related. This is due to the chaotic circumstances in which the victims find themselves. Therefore it may be hard to achieve consistency and appropriate sampling and controls. The climate of fear and mistrust left after a traumatic incident may undermine the co-operation of subjects.

- The questionnaires were not completed in the researcher's presence, therefore questions that lack clarity may have arisen of which the researcher is unaware. In measuring trauma, reliability of instruments could be doubtful, as they are not standardised on South Africans.

- The interviews conducted were mostly telephonic and therefore of limited scope, duration and where non-verbal messages could not be seen or interpreted.

- Some individuals were hijacked one week before the questionnaire was administered while others had been hijacked three years previously. This would affect the levels of the symptoms measured. In this sense the tests were therefore not homogeneous.

- Since it is not an area of extensive research, the results should be interpreted with caution.

- **Table 5.1** shows that although every attempt was made to keep the study "pure", previous traumas would have had an impact on the results. Death, divorce and physical abuse were the most common traumas experienced. Where "other" and "none of the above" were categorised, the respondents also included infertility and AIDS as causes of their trauma.

Table 4.11 Previous traumas that had a significant effect				
Person	**Frequency**		**Percentage**	
	Partner	Victim	Partner	Victim
Loss of loved one	22	24	24	26
Divorce	5	13	5	14
Physical abuse	9	6	10	7
Sexual abuse	3	0	3	0
Retrenchment	3	2	3	2
Other	8	12	9	13
None of the above	43	36	46	39

Despite these limitations, it is hoped that the primary findings of this study will stimulate further research on the secondary victim.

5.4 RECOMMENDATIONS FOR FUTURE RESEARCH

The following recommendations for future research were generated from the present study:

a. A longitudinal study to consider how relationships are affected after crime-related trauma based on the observation made by the researcher of many separations after robbery.

b. Devise a therapeutic programme that includes the secondary victims after a traumatic incident.

c. Consider apparently remote possible causes of and remedies for violent crime with a view to finding solutions of a more permanently effective nature.

d. A study is necessary as to the efficacy of present trauma debriefing methods as viable intervention techniques.

5.5 CONCLUSIONS REACHED FROM THIS STUDY

Although this research is of limited scope, conclusive evidence is presented concerning the effect of a traumatic incident on the secondary victim. Considering the findings of the empirical study and the closely related scores for anxiety, trauma, loss and

vulnerability, sufficient proof is provided to justify addressing the needs of the secondary or "hidden" victim.

The resultant behaviour of primary and secondary victims after a robbery reveals aggression, withdrawal, somatisation, symptoms of derealisation and the need to protect themselves with weapons. In addition to these diverse psychological or emotional consequences, the constant exposure to crime in South Africa challenges the victim/s capacity to generate coping responses. This study reveals that one of the victim's coping responses is to turn for social support but by doing so the support system itself may develop symptoms of traumatic stress.

With the growth in crime and violence and the probability of exposure either directly as a primary victim or indirectly as a secondary victim, crime-induced trauma as a result of carhijacking or armed robbery is one of the most critical psychological problems facing South Africans. Psychologists and researchers are aware of this and they have a professional, personal and moral responsibility to actively search for therapeutic solutions.

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APPENDIX A

TABLE A	Suggested Distinctions Between the Diagnostic Criteria for Primary, Secondary Traumatic Stress Disorder and Acute Stress Disorder	
PRIMARY	**SECONDARY**	**DSM-IV ACUTE STRESS DISORDER**
A. Stressor: Experienced and event outside the range of usual human experiences that would be markedly distressing to almost anyone; and event such as: 1. Serious threat to Self. 2. Sudden destruction of one's environs.	**A. Stressor:** Experienced and event outside the range of usual human experiences that would be markedly distressing to almost anyone; and event such as: 1.Serious threat to traumatized person (TP) 2.Sudden destruction of TP's environs	**A. Stressor:** The person has been exposed to a traumatic event in which both of the following were present. 1. Serious threat to self or others 2. Person's response involved intense fear helplessness or horror
B Reexperiencing Trauma Event 1. Recollections of event 2. Dreams of event 3. Sudden reexperiencing of event 4. Distress of reminders of event	**B Reexperiencing Trauma Event** 1.Recollections of event/TP 2.Dreams of event/TP 3.Sudden reexperiencing of event/TP 4. Reminders of TP events distressing	**B Reexperiencing Trauma Event** 1. Illusions, flashback episodes 2. Dreams and recurrent images of event 3. Reliving the experience 4. Distress on exposure to reminders of event
C. Avoidance/Numbing of Reminders 1. Efforts to avoid thoughts/feelings 2. Efforts to avoid activities/situations 3. Psychogenic amnesia 4. Diminished interest in activities 5. Detachment/estrangements from others 6. Diminished affect 7. Sense of foreshortened future	**C. Avoidance/Numbing of Reminders** 1. Efforts to avoid thoughts/feelings 2. Efforts to avoid activities/situations 3. Psychogenic amnesia 4. Diminished interest in activities 5. Detachment/estrangements from others 6. Diminished affect 7. Sense of foreshortened future	**C. Avoidance/Numbing of Reminders** 1. Efforts to avoid thoughts/feelings 2. Activities and situation 3. People and conversations
D. Persistent Arousal 1. Difficulty falling/staying asleep 2. Irritability or outbursts of anger 3. Difficulty concentrating 4. Hypervigilance for self 5. Exaggerated startled response. 6. Physiologic reactivity to cues	**D. Persistent Arousal** 1. Difficulty falling/staying asleep 2 Irritability or outbursts of anger 3 Difficulty concentrating 4 Hyper vigilance for TP 5 Exaggerated startled response 6 Physiologic reactivity to cues	**D. Persistent Arousal** 1. Difficulty sleeping 2. Irritability 3. Hyper vigilance 4. Exaggerated startled response 5. Motor restlessness
		E. Impairment in Functioning 1. Distress in social functioning 2. Occupational and inability to pursue some necessary task 3. Immobilized personal resources
		F. Dissociative Indicators/Avoidance Three or more of the following dissociative symptoms must occur: 1. Numbing, detachment or absence of emotional responsiveness 2. A reduction in awareness of his/her surroundings e.g. "being in a daze" 3. Derealization 4. Depersonalization 5. Dissociative amnesia i.e. inability to recall an important aspect of the trauma
Symptoms under one month duration are considered normal, acute, crisis-related reactions. Those not manifesting symptoms until six months or more following the event are delayed PTSD or STSD **The disturbance for a minimum of two days and a maximum for four weeks and occurs within four weeks of the traumatic event (Figley 1995:8) and http://www.behavenet.com/capsules/disorders/asd.htm**		

APPENDIX B

RESEARCH QUESTIONNAIRE – ON THE TRAUMATIC EFFECTS OF VIOLENT CRIME

MASTERS STUDY in PSYCHOLOGY

Dear Ma'am/Sir

All of us are busier these days than we should be. One knows how the little extras in the "in tray" receive our best intentions but in reality, we do not have the time to fulfil these intentions. In spite of this awareness, the urgency of understanding the effect of crime on our nation compels me to ask for your assistance. Take some time to assist Psychologists, Educators, and other victims in understanding the full impact of crime-related trauma. A well-known fact is that violence as a result of car-hijackings and armed robbery has reached disturbing proportions in South Africa. The alarming facts are that it is possible for an incident of this nature to **happen to anyone and more than once.**

The questionnaire, which I would like you to complete forms part of a research study to determine the comparative effects of a violent traumatic incident on the partner/spouse of the victim. The effect on the "closest supporter" of the victim is a new area of research in our country.

Research of this nature is only successful because of people like you- who are willing to give up their precious gift of time and effort. Participation in this study is voluntary. All information will be treated as confidential.

With much appreciation for investing your time, and for sharing your "expert" experience in this study.

Very Sincerely Yours

Fiona Stansfeld

QUESTIONNAIRE TO BE COMPLETED BY THE VICTIM AND THE PARTNER

TRAUMATIC EFFECTS OF VIOLENT CRIME

The researcher is interested in:

UNDERSTANDING THE DIFFERENCE IN EXPERIENCES FOR THE VICTIM AND THE LOVED ONE AFTER A HIJACKING OR ARMED ROBBERY.

CONSENT FORM PART I

I have been informed as to the purpose of this study.	YES	NO
I hereby agree to participate in the above study.	YES	NO
I agree to complete the questionnaire for research purposes.	YES	NO
I will be available for a telephonic interview in order to provide further depth and clarity to the findings.	YES	NO
I understand that my confidentiality is protected.	YES	NO

It would be appreciated if you would complete these details below in case I need to clarify anything with you. You are most welcome to phone me for results of research findings.

NAME: _____

SIGNED: _____

ADDRESS: _____

_____

E-MAIL _____

TELEPHONE NUMBERS: _____

_____

_____

BIOGRAPHICAL INFORMATION OF PERSON COMPLETING QUESTIONNAIRE

PLEASE DO NOT LEAVE ANY QUESTIONS OUT-THROUGHOUT

OFFICIAL USE

QUESTIONAIRE #

[ ] [ ] [ ]
1 2 3

PART II

1. Are you the :

Partner	1	[ ]
Victim	2	4

2. Your highest qualification/standard passed:

Pre-matric	1	
Matric	2	
Graduate	3	[ ]
Post-Graduate	4	5

3. Your gender:

Male	1	[ ]
Female	2	6

4. Your age:

18 - 29 years	1	
30 - 39 years	2	
40-49 years	3	[ ]
50 + years	4	7

5. Your race:

White	1	
Black	2	
Coloured	3	[ ]
Indian	4	8
Asian	5	

6. When did the incident take place?

Less than 3 months ago	1	
3 - 6 months ago	2	
7 - 12 months ago	3	[ ]
12 + months ago	4	9

OFFICIAL USE

7. **What is your relationship with the other person involved in this experience:**

Spouse	1	
Partner	2	
Friend	3	10
Parent	4	
Child	5	
Other-namely	6	

8. **Where do you live?**

Johannesburg	1	
East Rand	2	
Pretoria	3	11

9. **What happened to you?**

Were you hijacked?	1	
Were you robbed?	2	
Both?	3	
None of the above	4	12

10. **Did any of your children witness the event?**

Yes	1	
No	2	13

11. **How long have you been in this relationship?**

0 - 6 months	1	
7 - 12 months	2	14
12 - 24 months	3	
2 + years	4	

OFFICIAL USE

12. Was the victim hurt?

Not	1	
Wounded	2	
Shot	3	
Killed	4	15

13. Income bracket (per month)

R5 000 - R9 999	1	
R10 000 - R19 999	2	
R20 000 - R29 000	3	
R30 000 - R40 000(+)	4	16

14. How many times have you experienced a car hijacking / armed robbery:

Once	1	
Twice	2	
Three times	3	
Four or more times	4	17

15. If you have experienced any of the following traumas, which in your opinion had the most effect on you.

Physical abuse	1	
Divorce	2	
Loss of loved one	3	
Retrenchment	4	
Sexual abuse	5	
None of the Above	6	
Other, namely	7	18

16. Name the single most important person from whom you asked advice after the hijacking/robbery.

Therapist	1	
Friend	2	
Parent	3	
Colleague	4	
Spiritual Leader	5	
No one	6	
Other, namely	7	
None of the Above	8	19

OFFICIAL USE

17. When did you ask for help?

Within a week	1	
1-2 months	2	
3-6 months	3	☐
7-12 months	4	20
1 year plus	5	

18. Which was the single most noticeable coping method used by you after the incident.

Shopped compulsively	1	
Ate more than before	2	
Withdrew socially	3	
Drank more alcohol	4	
Delved into work / studies	5	☐
Became more aggressive	6	21
None of the above	7	
Other, namely	8	

19. Developed physical symptoms - mark the one most applicable to you

Heart palpitations	1	
Chest pains	2	
Stomach ache	3	
Headaches	4	
None of the above	5	☐
All of the above	6	22
Other, namely	7	

20. Were you hospitalized after the incident?

Yes	1	☐
No	2	23

There are four **STANDARISED QUESTIONNAIRES** that follow. Please complete **ALL FOUR** for research purposes.

OFFICIAL USE

STANDARDISED QUESTIONNAIRES
SASRQ- SCALE
PART III - 1

Recall the stressful events that occurred in your life.

How disturbing was the event to you? (Please mark one):

21. Not at all disturbing [1]
Moderately disturbing [2]
Very disturbing [3]

[ ] 24

INSTRUCTIONS: Below is a list of experiences people sometimes have during and after a stressful event. Please read each item carefully and decide how well it describes your experiences. Refer to the crime-related traumatic event in answering the items that mention "the stressful event". Use the 0 - 5 point scale below and indicate the number that best describes your experience.

0	1	2	3	4	5
Not	Very rarely	Rarely	Some times	Often	Very often

e x p e r i e n c e d

1.	I had difficulty falling or staying asleep.	[ ]	[ ] 25
2.	I felt restless.	[ ]	[ ] 26
3.	I felt a sense of timelessness.	[ ]	[ ] 27
4.	I was slow to respond.	[ ]	[ ] 28
5.	I tried to avoid feelings about the hijacking/robbery.	[ ]	[ ] 29
6.	I had repeated distressing dreams of the hijacking / robbery.	[ ]	[ ] 30
7.	I felt extremely upset if exposed to events that reminded me of an aspect of the hijacking/robbery.	[ ]	[ ] 31
8.	I would jump in surprise at the least thing.	[ ]	[ ] 32

			OFFICIAL USE
9.	The hijacking / robbery made it difficult for me to perform work or other things I needed to do.	☐	☐ 33
10.	I did not have the usual sense of who I am.	☐	☐ 34
11.	I tried to avoid activities that remind me of the event.	☐	☐ 35
12.	I felt hypervigilant or "on edge".	☐	☐ 36
13.	I experienced myself as though I were a stranger.	☐	☐ 37
14.	I tried to avoid conversations about the hijacking / robbery.	☐	☐ 38
15.	I had a bodily reaction when exposed to reminders of the hijacking/robbery.	☐	☐ 39
16.	I had problems remembering important details about the hijacking / robbery.	☐	☐ 40
17.	I tried to avoid thoughts of the stressful event.	☐	☐ 41
18.	Things I saw looked different to me from how I know they really looked.	☐	☐ 42
19.	I had repeated and unwanted memories of the event.	☐	☐ 43
20.	I felt distant from my own emotions.	☐	☐ 44
21.	I felt irritable or had outbursts of anger.	☐	☐ 45
22.	I avoided contact with people who reminded me of the stressful event.	☐	☐ 46

			OFFICIAL USE
23.	I would suddenly act or feel as if the event was happening again.	☐	☐ 47
24.	My mind went blank.	☐	☐ 48
25.	I had amnesia for long periods of the stressful event.	☐	☐ 49
26.	The event caused problems in my relationships with other people.	☐	☐ 50
27.	I had difficulty concentrating.	☐	☐ 51
28.	I felt estranged or detached from other people.	☐	☐ 52
29.	I had a vivid sense that the event was happening all over again.	☐	☐ 53
30.	I tried to stay away from places that reminded me of the stressful event.	☐	☐ 54

SCHILLACE TRAUMA SCALES

PART IV - 2

L - Scale

DIRECTIONS: Please indicate if you believe the statements below are either TRUE or FALSE as they apply to you. Place a number 1 or 2 in the block. 1 = TRUE : 2 = FALSE.

Mark only 1 or 2 !

OFFICIAL USE

1.	I am not especially irritable these days.	☐	☐ 55
2.	I feel that I have changed in a deep and significant way as a result of the recent events in my life.	☐	☐ 56
3.	I feel something terrible has happened to me and I am surprised because I thought I was a good person and would be protected.	☐	☐ 57
4.	I have frequent periods of weeping.	☐	☐ 58
5.	I feel a general sense of helplessness.	☐	☐ 59
6.	I have a feeling that something or someone has been taken from me and I desperately want "it" back.	☐	☐ 60
7.	Sometimes it "hits me" all of a sudden that something terrible has happened.	☐	☐ 61
8.	I have felt a profound lack of preparation for certain important and recent events in my life.	☐	☐ 62
9.	I am frequently overcome with uncontrollable waves of sadness.	☐	☐ 63
10.	Events (holidays and anniversaries) or objects (clothing, pictures etc.) which remind me of a lost loved-one produce strong emotions in me.	☐	☐ 64
11.	Sometimes I feel like I am "coming apart" and having a nervous breakdown.	☐	☐ 65

	1 = TRUE 2 = FALSE		OFFICIAL USE
12.	I used to feel life made sense and was understandable; now it seems confusing and meaningless.	☐	☐ 66
13.	My strongest emotion these days is depression.	☐	☐ 67
14.	My motivation to work these days is normal.	☐	☐ 68
15.	My holidays are very sad for me.	☐	☐ 69
16.	I am generally calm and patient.	☐	☐ 70
17.	I feel healthy and not sickly.	☐	☐ 71
18.	I have this sense that something terrible has happened, but at the same time I can't believe it has.	☐	☐ 72
19.	I feel calm and seldom fidget.	☐	☐ 73
20.	I feel secure.	☐	☐ 74
21.	My sleep is normal; I sleep well at night and don't feel the need to sleep during the day.	☐	☐ 75
22.	I feel I am being punished, but don't know why.	☐	☐ 76
23.	I find it difficult to separate from loved ones; I become sad when they leave me.	☐	☐ 77
24.	It seems like I have been sad for a long time while at the same time it seems that what made me sad just happened "yesterday".	☐	☐ 78
25.	Time seems to move very slowly these days.	☐	☐ 79

1 = TRUE 2 = FALSE **OFFICIAL USE**

26. I have a sense that something or someone is missing and that I am searching for "it". ☐ ☐ 80

27 My understanding of myself and the world have been forced to change as a result of recent events in my life. ☐ ☐ 81

28 I used to have a sense that life was good; now it seems empty and hurtful. ☐ ☐ 82

29 I have very fond memories of what I have lost - nothing seems quite as good or could ever replace it. ☐ ☐ 83

30. I have no trouble making decisions. ☐ ☐ 84

PART V
T- Scale

Please indicate if you believe the statements below are either

1 - TRUE or **2 - FALSE** as they apply to you.

31. I feel very hurt (emotionally) by recent events in my life. ☐ ☐ 85

32. I do not try to avoid places that remind me of being hurt. ☐ ☐ 86

33. Sometimes I feel so nervous that I can't seem to do simple, normal activities. ☐ ☐ 87

34. I believe I am safe even if the world is dangerous. ☐ ☐ 88

35. Many events seem unbearably stressful to me. ☐ ☐ 89

	1 = TRUE 2 = FALSE		OFFICIAL USE
36	I often experience an inability to think clearly because I am so nervous.	☐	☐ 90
37.	I have this feeling that I must remain on the look-out for something out there that can hurt me.	☐	☐ 91
38.	Taking risks has not become more difficult for me.	☐	☐ 92
39.	At night I frequently find myself awake and frightened, but I don't know what of.	☐	☐ 93
40.	My tolerance for stress seems much the same as it has always been.	☐	☐ 94
41.	I feel that my loved ones are not as safe as they used to be.	☐	☐ 95
42.	I feel that I have control of my life.	☐	☐ 96
43.	I do not worry that something terrible has happened to a loved one when he/she is late.	☐	☐ 97
44.	I used to feel that the world was fair and just - now it seems so unfair; I don't understand it.	☐	☐ 98
45.	I am not easily distracted, therefore have no difficulty concentrating.	☐	☐ 99
46.	Currently, my sexual performance seems relaxed and controllable.	☐	☐ 100
47.	I have a kind of nervous energy these days, which keeps me from resting.	☐	☐ 101
48.	I have confidence in myself and have no problem relating to others.	☐	☐ 102

	1 = TRUE 2 = FALSE		OFFICIAL USE
49.	More so than other times in my life, I feel that the world is a dangerous place.	☐	☐ 103
50.	I feel my body has changed significantly in a negative way.	☐	☐ 104
51.	My experience has been that a person can be fine one moment and terribly hurt and changed the next.	☐	☐ 105
52.	I often feel exposed and unprotected in the world.	☐	☐ 106
53.	I feel overwhelmed with fear when I talk about certain events.	☐	☐ 107
54.	There are times when for no good reason, all at once, I find my heart pounding, my breathing getting faster, my knees shaking and I have a sense of weakness and light-headedness.	☐	☐ 108
55.	I have a sense of inner peace and calm.	☐	☐ 109
56.	I have not lost my sense of physical health and well being.	☐	☐ 110
57.	I have this awareness that something hurtful could happen to me or to a loved-one like a "bolt from the sky" with no warning.	☐	☐ 111
58	"Surprises", like someone coming up quickly behind me, do not upset me or make me jumpy.	☐	☐ 112
59.	I find myself developing fears, which do not make sense.	☐	☐ 113
60.	I have this nagging sense that something "bad" (harmful) is going to happen.	☐	☐ 114

1 = TRUE 2 = FALSE

OFFICIAL USE

61. Certain places or activities (eg. Riding in a car, being at work, hearing a siren) make me very nervous. ☐ ☐ 115

62. I feel no need to calm myself down with drugs (legal or illegal) or alcohol. ☐ ☐ 116

63. I can be away from home for long periods without feeling nervous and anxious to get back there. ☐ ☐ 117

64. I do not seem to be any more emotionally uncomfortable at night than I used to be. ☐ ☐ 118

65. I am developing involuntary mannerism or ticks. ☐ ☐ 119

66. I am troubled by repetitive memories and mental images of a recent painful or frightening event. ☐ ☐ 120

PART VI
V- Scale

Please indicate if you believe the statements below are either **1 - TRUE** or **2 - FALSE** as they apply to you.

67. I have had many narrow escapes in life and I feel as though my "nine lives" are almost up. ☐ ☐ 121

68. I feel as though there is punishment "hanging over my head", ready to drop at any time. ☐ ☐ 122

69. If something terrible is going to happen, it will happen to me. ☐ ☐ 123

70. Taking chances for the thrill of it makes life more exciting for me. ☐ ☐ 124

71. Regarding disappointment and tragedy, I am no longer sure that it will happen to the other man/woman, and not me. ☐ ☐ 125

	1 = TRUE 2 = FALSE		OFFICIAL USE
72.	I am confident I will be spared terrible misfortunes.	☐	☐ 126
73.	It seems that almost everywhere I look I see danger.	☐	☐ 127
74.	Usually I feel as safe when I am alone as when I am with someone.	☐	☐ 128
75.	I feel I have more than my fair share of bad luck.	☐	☐ 129
76.	Frequently when the telephone rings or I receive a letter I become frightened that it will be bad news.	☐	☐ 130
77.	I can handle most dangers in the world.	☐	☐ 131
78.	I seldom worry that people I love will get hurt or be taken away from me.	☐	☐ 132
79.	The world seems harsh and hurtful - not helpful.	☐	☐ 133
80.	I often feel that something terrible is going to happen to someone close to me.	☐	☐ 134
81.	I used to feel safe, but now I feel horrible things can happen to nice people, me included.	☐	☐ 135
82.	I control my well-being.	☐	☐ 136
83.	I welcome challenges.	☐	☐ 137
84.	Sometimes I feel "exposed" and unprotected and that I could easily be hurt (either physically or emotionally).	☐	☐ 138
85.	I feel it is important to always keep my guard up and to be alert to possible threats.	☐	☐ 139

1 = TRUE 2 = FALSE

OFFICIAL USE

86. I feel there are very few real threats to my safety that I cannot handle. ☐ ☐ 140

87. Sometimes I can't stand being alone. ☐ ☐ 141

88. I get angry at family or friends who need to warn me about dangers in my work\life. ☐ ☐ 142

89. Evil and pain are very real to me. ☐ ☐ 143

90. Taking risks feels good to me. ☐ ☐ 144

D- SCALE
PART VII -3

INSTRUCTIONS: Read the statements in each of the categories and mark the number of the statement that fits you best over the past two weeks including today. today.

91. Mood

I do not feel sad.	1
I feel blue or sad.	2
I am sad all the time and I can't snap out of it.	3
I am so sad or unhappy that I can't stand it.	4

☐ 145

92. Pessimism

I am not particularly discouraged about the future.	1
I feel discouraged about the future.	2
I feel I have nothing to look forward to.	3
I feel that the future is hopeless and that things will never improve.	4

☐ 146

93. Sense of failure

I do not feel like a failure.	1
I feel I have failed more than the average person.	2
As I look back on my life all I see is a lot of failures.	3
I feel I am a complete failure as a person.	4

☐ 147

OFFICIAL USE

Read the statements in each of the categories and mark the statement that describes you best over the past two weeks including today.

94. Lack of satisfaction

I am not particularly dissatisfied.	1
I don't enjoy things the way I used to.	2
I don't get satisfaction out of anything anymore.	3
I am dissatisfied with everything.	4

148

95. Guilty feeling

I don't feel particularly guilty.	1
I feel guilty a good part of the time.	2
I feel quite guilty most of the time.	3
I feel guilty all of the time.	4

149

96. Sense of punishment

I don't feel I am being punished.	1
I have a feeling that something bad may happen to me.	2
I expect to be punished.	3
I feel I deserve to be punished.	4
I feel I am being punished.	5

150

97. Self-hate

I don't feel disappointed in myself.	1
I am disappointed in myself.	2
I am disgusted with myself.	3
I hate myself.	4

151

98. Self accusations

I don't feel I am worse than anybody else.	1
I am very critical about myself and my weaknesses and mistakes.	2
I blame myself all the time for my faults.	3
I blame myself for everything bad.	4

152

OFFICIAL USE

Read the statements in each of the categories and mark the statement that describes you best over the past two weeks and today.

99. Self-punitive wishes

I don't have any thoughts of killing myself.	1
I have thoughts of killing myself but would not carry them out.	2
I feel I would be better off dead.	3
I would kill myself if I could.	4

153

100. Crying spells

I don't cry any more than usual.	1
I cry more now than I used to.	2
I cry all the time now.	3
I used to be able to cry but now I can't cry at all even though I want to.	4

154

101. Irritability

I am no more irritated now than I ever am.	1
I get annoyed or irritated more easily than I ever used to.	2
I feel irritated a good deal of the time.	3
I feel irritated all the time now.	4

155

102. Social withdrawal

I have not lost interest in other people.	1
I am less interested in other people now more than I used to be.	2
I have lost most of my interest in other people and have little feeling for them.	3
I have lost all my interest in other people.	4

156

OFFICIAL USE

Read the statements in each of the categories and mark the the statement that describes you best over the past two weeks and at the present time.

103. Indecisiveness

I make decisions about as well as ever.	1
I am less sure of myself now and try to put off making decisions.	2
I can't make decisions any more without help.	3
I can't make decisions at all any more.	4

157

104. Body image

I don't feel I look any worse than I used to.	1
I am worried that I am looking old or unattractive.	2
I feel that there are permanent changes in my appearance and they make me look unattractive.	3
I feel I am ugly or repulsive looking.	4

158

105. Work inhibition

I work as well as I used to.	1
It takes extra effort to get started at doing something.	2
I have to push myself very hard to do something.	3
I can't do any work at all.	4

159

106. Sleep disturbance

I can sleep as well as usual.	1
I don't sleep as well as I used to.	2
I wake up one-two hours earlier and find it hard to go back to sleep.	3
I wake up early every day and can't get more than five hours sleep.	4

160

107. Fatigability

I don't get more tired than usual.	1
I get tired more easily than I used to.	2
I get tired from doing almost anything.	3
I am too tired to do anything.	4

161

OFFICIAL USE

Read the statements in each of the categories and mark the statement that describes you best over the past two weeks and at the present time.

108. Loss of appetite

My appetite is no worse than usual.	1
My appetite is not as good as it used to be.	2
My appetite is much worse now.	3
I have no appetite at all anymore.	4

162

109. Weight loss

I haven't lost so much weight, if any lately.	1
I have lost more than 2kg.	2
I have lost more than 5kg.	3
I have lost more than 7kg.	4

163

110. Somatic preoccupation

I am no more concerned about my health than usual.	1
I am concerned about aches and pains or an upset stomach or constipation or other unpleasant feelings in my body.	2
I am very concerned about physical problems and it is hard to think of much else.	3
I am so worried about my physical problems that I cannot think about anything else.	4

164

111. Loss of libido

I have not noticed any recent change in my interest in sex.	1
I am less interested in sex than I used to be.	2
I am much less interested in sex now.	3
I have lost interest in sex completely.	4

165

OFFICIAL USE

A-SCALE

PART VIII- Questionnaire Number -4

INSTRUCTIONS: Read the statements in each of the categories and mark the symptoms that have been bothering you over the past two weeks and at the present time.

112. Numbness or tingling

Not at all. 1
Mildly - it did not bother me much. 2
Moderately-it was very unpleasant but I could stand it. 3
Severely- I could barely stand it. 4

166 ☐

113. Feeling hot

Not at all. 1
Mildly - it did not bother me much. 2
Moderately-it was very unpleasant but I could stand it. 3
Severely- I could barely stand it. 4

167 ☐

114. Wobbliness in legs

Not at all. 1
Mildly - it did not bother me much. 2
Moderately-it was very unpleasant but I could stand it. 3
Severely- I could barely stand it. 4

168 ☐

115. Unable to relax

Not at all. 1
Mildly - it did not bother me much. 2
Moderately-it was very unpleasant but I could stand it. 3
Severely- I could barely stand it. 4

169 ☐

116. Fear of the worst happening

Not at all. 1
Mildly - it did not bother me much. 2
Moderately-it was very unpleasant but I could stand it. 3
Severely- I could barely stand it. 4

170 ☐

OFFICIAL USE

Read the statements in each of the categories and mark the statement that fits you best over the past two weeks and at the present time.

117. Dizzy or lightheaded

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	
Severely- I could barely stand it.	4	171

118. Heart pounding or racing

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	
Severely- I could barely stand it.	4	172

119. Unsteady

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	
Severely- I could barely stand it.	4	173

120. Terrified

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	
Severely- I could barely stand it.	4	174

121. Nervous

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	
Severely- I could barely stand it.	4	175

OFFICIAL USE

Read the statements in each of the categories and mark the statement that fits you best over the past two weeks and at the present time.

122. Feelings of choking

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	
Severely- I could barely stand it.	4	176

123. Hands trembling

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	
Severely- I could barely stand it.	4	177

124. Shaky

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	
Severely- I could barely stand it.	4	178

125. Fear of losing control

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	
Severely- I could barely stand it.	4	179

OFFICIAL USE

Read the statements in each of the categories and mark the statement that fits you best over the past two weeks and at the present time.

126. Difficulty breathing

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	☐
Severely- I could barely stand it.	4	180

127. Fear of dying

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	☐
Severely- I could barely stand it.	4	181

128. Scared

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	☐
Severely- I could barely stand it.	4	182

129. Indigestion or discomfort in abdomen

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	☐
Severely- I could barely stand it.	4	183

130. Faint

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	☐
Severely- I could barely stand it.	4	184

OFFICIAL USE

Read the statements in each of the categories and mark the statement that fits you best over the past two weeks and at the present time.

131. Face flushed

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	☐
Severely- I could barely stand it.	4	185

132. Sweating (not due to heat)

Not at all.	1	
Mildly - it did not bother me much.	2	
Moderately-it was very unpleasant but I could stand it.	3	☐
Severely- I could barely stand it.	4	186

THANKYOU FOR COMPLETING THIS QUESTIONNAIRE

APPENDIX C

Scoring of the three standardised questionnaires

1. Scoring of the Stanford Acute Stress Reaction Questionnaire (SASRQ)

A. Traumatic Event

The rating scale from "not at all disturbing" to "extremely disturbing" assesses the intensity of the person's response.
Dissociative symptoms:

1) Subjective sense of numbing, detachment, or absence of emotional responsiveness
Items 20,28

2) A reduction in awareness of ones surroundings
Items 4, 24

3) Derealization
Items 3,18

4) Depersonalization
Items 10.13

5) Dissociative amnesia
Items 16,25

6) The traumatic event is persistently experienced
Items 6,7,15,19,23,29

7) Marked avoidance of stimuli that arouse recollections of the trauma
Items 5,11,14,17,22,30

8) Marked symptoms of anxiety or increased arousal
Items 1, 2, 8, 12, 21,27

9) Impairment in functioning
Items 9,26

0 = not, 1 = very rarely, 2 = rarely, 3 = sometimes, 4 = often, 5 = very often experienced

2. Schillace Trauma Scales

A. Schillace Loss Scale

Items answered false receive 1 point each: 1,14,16,17,19, 20, 21, 30
Items answered true receive 1 point each: 2, 32, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 18, 22, 23, 24, 25, 26, 27, 28, 29

B. Schillace Vulnerability scale

Items answered false – 1 point each: 4, 6, 8,11,12,16,17,20,22,24
Items answered true – 1 point each: 1, 2, 3, 5, 7, 9, 10, 13, 14, 15, 18, 19, 21, 23

C. Schillace Trauma scale

False scores – 1 point: 2, 4, 8, 10, 12, 13, 15, 16, 18, 25, 26, 28, 32, 33, 34
True scores – 1 point: 1, 3, 5, 6, 7, 9, 11, 14, 17, 19, 20, 21, 22, 23, 24, 27, 29, 30, 31, 35, 36, 37

3. Becks' Depression Inventory

A numerical value ranging between nought and three is attributed to a statement depending on its intensity

0 – 9:	No depression
10 –15:	Mild
16 – 23:	Moderate
24 – 63:	Severe

APPENDIX D

How many times was the incident experienced - VICTIM

Number of times	Frequency	Percentage
Once	70	75.27
Twice	15	16.13
Three +	8	8.60

When did it happen - Victim

< 3 months	16	17,20
3-6 months	17	35.48
7-12 months	6	41.94
12+ months	54	100

What happened - Victim

Not wounded	73	78.49
Wounded	12	12.90
Shot	8	8.60

How disturbing was the event - VICTIM

How disturbing	Frequency	Percentage
Not disturbing	2	2.15
Moderately disturbing	30	32.26
Very disturbing	61	65.59

How disturbing was the event - PARTNER

How disturbing	Frequency	Percentage
Not disturbing	1	1.08
Moderately disturbing	19	20.43
Very disturbing	73	78.49