Lessons from research: What we do and don’t know about the health benefits of RJ for victims of crime.

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Impact of Criminal Victimisation on Health and Well-Being
## Costs of Victimisation

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<th>Personal Costs</th>
<th>Interpersonal Costs</th>
<th>Economic Costs</th>
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<td>Marital breakdown</td>
<td>Resultant un or under employment</td>
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<td>Emotional distress</td>
<td>Impact on role as carer or parent</td>
<td>Absenteeism from work</td>
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<td>Loss of sense of personal agency and desired life path</td>
<td>Social withdrawal from active citizenship</td>
<td>Greater use of medical services</td>
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<td>Loss of sense of safety and trust in others</td>
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<td>Criminal justice system and associated support agencies</td>
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<td>Loss of hope for the future</td>
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<td>Mental health services</td>
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<td>Decline in physical health</td>
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The example of the long-term health impacts of childhood sexual abuse

- Poorer general health and having more negative perceptions of their overall physical health = greater use of health services
- Autoimmune system diseases – fibromyalgia, Crohn’s, Type 1 diabetes, rheumatoid arthritis
- Gastro-intestinal problems such as irritable bowel syndrome, ulcers
- Gynaecological symptoms such as chronic pelvic pain, pelvic inflammatory disease
- Pain such as headaches, backaches, muscle aches and joint pain
- Cardiopulmonary symptoms and disorders
- Lung disease
- Hepatitis
- Substance misuse
- Sexually transmitted diseases
- Medically unexplained symptoms
- Dementia
Pathways to indirect effects of victimisation on health
The Human Stress Response: Coordinated through two distinct bio-physiological pathways

**Autonomic Nervous System:**
Fight/Flight/Freeze response

**Hypothalamic-pituitary-adrenocortical activation**
Balanced Nervous System:
- High Energy
- Mentally Alert
- Few Symptoms
- Excellent Health
- Resistant to Infections
- Positive Mental Attitude
- Vibrant

Unbalanced Nervous System:

Under-Aroused:
- Poor Attention
- Impulsive
- Easily Distracted
- Disorganised
- Depressed
- Lacking motivation
- Poor Concentration
- Spaciness
- Constipation
- Low pain threshold
- Difficulty waking
- Worry
- Irritable
- Low energy

Unstable:
- Migraines
- Headaches
- Seizures
- Sleepwalking
- Hot flushes
- PMS
- Food sensitivities
- Bed wetting
- Eating disorders
- Bi-polar disorders
- Mood swings
- Panic attacks

Over-Aroused:
- Cold hands
- Cold feet
- Tight Muscles
- Teeth grinding
- Anxiety
- Heart palpitations
- Restless sleep
- Poor expression of emotions
- Poor immune system
- Racing mind
- High blood pressure
- Accelerated aging
- Irritable bowel

Exhausted Nervous System:
- Cancer
- Rheumatoid Arthritis
- Diabetes
- Multiple Sclerosis
- Depression
- Chronic Fatigue Syndrome
- Fibromyalgia
- ALS
- Epstein-Barr Syndrome

Compiled from the work by Siegfried Othmer, Susan F. Othmer, and David A. Kaiser EEG Biofeedback: A Generalized Approach to Neuroregulation.
Post-traumatic Stress Disorder

Can be conceptualised as a form of chronic stress

To be diagnosed with PTSD the symptoms would need to persist for more than 6 months.

Some people may develop sub-syndromal post-traumatic stress symptoms in the aftermath of trauma, which may develop into full blown PTSD by exposure to a relatively mundane stressor.
Post traumatic symptoms are associated with a number of health indicators

• Even low levels of symptoms are associated with:
  • Poorer overall health functioning
  • Greater utilisation of medical services
  • Greater intensity of physical symptoms
  • Higher rates of morbidity and mortality from coronary heart disease
PTSD is a risk factor a variety of health conditions

- **Dementia** – Yaffe et al. (2010) - retrospective cohort study of 181,093 US veterans over the age of 55 (mean 68.8 years) (53,155 who were diagnosed with PTSD)
  - Explored the 7-year cumulative incidence of dementia – 10.6% for those with PTSD and 6.8% for those without.
  - After controlling for factors such as age, demographics, history of head injury, substance misuse or clinical depression veterans with PTSD were almost 2X to develop dementia
The potential of RJ to ameliorate health problems: Theoretical Perspectives

Collins (2004) 4 main ingredients for a successful ritual:

• group assembly,
• a barrier to outsiders,
• mutual focus
• a shared mood.

Participants get “caught up in the rhythm and mood of the talk” (Collins 2004, p. 48) - collective effervescence
The immediate result...

- exhibitions of signs of high levels of solidarity between each other.

- a synchronization of gestures and movements at the micro level, including head nodding, smiling, eye contact and other gestures (Collins 2004, p 75).

- feelings of group membership.

- feeling like they belong.
And longer-term....

• solidarity is turned into a long-term feeling of emotional energy.

• This is a combination of positive feelings that sustains a person between interactions.

• Collins suggests that “high emotional energy is a feeling of confidence and enthusiasm for social interaction”

• High emotional energy also includes initiative, and pride

• People with high levels of emotional energy are more disposed to trust others

• It is a central motivating force for individuals and encourages them to maintain the social order (Fine 2005).
So Rossner (2007) argues....

- Participants leave their conference with the short term outcome of feelings of group membership and social bonds, paving the way to high levels of emotional energy.
Narrative theory and potential health benefits of RJ for victims

• Victims get to tell their story directly to the character who has been suddenly thrust into their narrative.

• Freud and Jung - as mentally and spiritually redeeming storytelling.

• aboriginal cultures place great significance on the power of stories to heal and to bind communities together.
• Andrew Frank (1995) - storytelling and illness
  ○ reconstructive process that offers kind of meta-control following loss.

• Serious illness is a loss of the "destination and map" that had previously guided the person's life: ill people have to learn to "think differently."

• They learn by hearing themselves tell their stories, absorbing others' reactions, and experiencing their stories being shared (Frank 1995:1).
• Stories are "successfully accomplished" through interactions with others.
  • That is, stories do not make sense unless they are linked to others' stories: "every victim requires an offender" to fulfil that role assigned in the story.

• The critical factor is the process that "the story ignites" in both the teller and the listener (Simpkinson 1993).

• Stories help make sense of confusing experiences
The creation of such accounts is motivated by peoples’ needs for meaning:

• Meaning making is an important stage in the recovery process (Herman 1992).

• Meaning-making is associated with the need:
  
  • to see events as causally linked;
  
  • to affirm one's sense of moral right and wrong;
  
  • for a belief in personal efficacy;
  
  • to defuse potential threats to self-worth (Baumeister & Newman 1994).
Therapeutic process of story-telling

• Talking about a trauma brings about striking reductions in blood pressure, muscle tension, and skin conductance during and immediately after such disclosure (Pennebaker 1993).

• Benefits are more apparent for those who express emotion, as opposed to simply giving a dry recounting of the facts (Pennebaker 1993).

• People often experience a reduction in anxiety.
The potential of RJ to ameliorate health problems? The empirical findings so far
 Reported victim outcomes following RJ

Strang (2002)
• Australia – 232 victims of property and violent offences who were randomly assigned to court or RJ conference

Shapland et al. (2007)
• Randomised control trial of burglary and robbery victims – cases either proceeded to court only or through court and RJ conference – outcome assessment – 8-9 months post conference

• Angel (2005); Angel et al. (2014)

• Reduction in :
  • desire for revenge
  • Fear and anger towards the offender
  • Anger towards the CJS
  • Embarrassment and shame about the event(s)
  • Anxiety
  • Post-traumatic stress symptoms

• Achieve or move towards emotional closure

• Greater sense of satisfaction in how their case is handled.

• Improvements in sense of dignity, confidence and self-respect
Angel (2005): Post-traumatic stress symptoms

- Random RJ allocation in addition to court vs court only group

- Victims of Burglary and Robbery – who had low to moderate levels of PTSS

- Follow-up
  - 6 weeks post-conference – Conference group have 33% less PTSS than the control group
  - 6 months post-conference - Conference group 40% less PTSS than the control group
  - Whilst both the control group and conference group demonstrate progress towards healing over time, the conference group did so at a faster rate
Angel et al. (2014) – London Met. Police

- Random allocation of Burglary (n=135) and Robbery (n=100) victims to court + conference (n=89) or court only (103)
- All offenders had plead guilty and were on remand (pre-sentencing)
- Offenders aged over 17 and all were consenting
- Most offenders were strangers to the victims
- Only 14% of the victims had been physically injured as a consequence of the victimisation
- PTSS scores on the Impact of Events scale collected 30 days post allocation to RJ group, which was on average 6 months after the victimisation experience
Findings

• 24.3% of the control group victims had clinical levels of PTSS indicative of warranting a diagnosis of PTSD 30 days after random allocation (6 months post victimisation)

• Only 12.4% of the RJ+ court group had equivalent PTSS scores

• Overall the PTSS scores were almost twice as high in the court only group in comparison to the RJ + court group.

• Lower scores were evident in two of the three subscales: intrusions and avoidance, but at this stage there appeared to be no benefit for hyper-arousal. It may be that this takes longer to dissipate following intervention.
Where are the gaps and how can these be bridged?
What we know and what we don’t yet know

• Impact has only been assessed for pre-sentencing and not post-sentencing

• We have evidence for system initiated RJ, but not victim-requested RJ

• Due to the offences covered in the previous studies we only know about impact for victims whose offenders were mostly strangers and who were not physically harmed or feared for their life as part of the crime – thus we do not know if the findings will generalise to crimes perpetrated by someone know to the victim or more serious violent and sexual crimes.

• Angel’s study has not included base-line measures, thus we cannot be certain that the control and experimental groups did not differ in terms of their PTSS scores before allocation to the groups
The future?
Evaluations of the potential health benefits of RJ might want to consider the following:

Ensure both pre- and post intervention assessments are made of health outcomes

Longer-term follow-up – maybe 6 months or a year after intervention (controlling for new stressors)

Explore whether the PTSS findings apply in different contexts
  • point at which RJ is delivered – pre-sentencing, post-sentencing, as a diversion from court, system initiated, victim-requested, direct versus indirect (e.g. shuttle and surrogate) methods of RJ
  • forms of victimisation – direct and indirect victims, victims of sexual and violent crimes
  • Relationship between the victim and the offender – stranger, acquaintance, friend, family, intimate partner etc.

• To ALSO capture health benefits of RJ through the use of objective biological and physiological markers using non-invasive procedures – e.g. salivary levels of cortisol (the primary stress hormone which appears to be implicated in PTSD)
Conclusion

• 30% of crime victims are estimated to have full-blown PTSD (Kilpatrick et al., 1987)
  • Angel et al.’s study highlighted that only 1/3 of those whose PTSS scores were suggestive of them having full-blown PTSD had sought counselling for help with their symptoms – so the 30% above, might be an underestimation.

• Female victims of crime evidence 3X the rate of PTSD as do female non-victims (Kilpatrick, Resnick, Saunders, & Best, 1989).

• PTSD is associated with an average loss of 24 working days per year per person affected by it

• 42% of those suffering from PTSD are no longer in full-time employment – thus they will be typically claiming benefits

• Average waiting time for CBT for PTSD in the UK in 2013 is 9 months – and it appears that the majority of crime victims do not seek psychotherapy to deal with their symptoms

• If Angel et al.’s findings are both reliable and generalizable to other contexts it would appear that RJ has significant potential to ameliorate the pernicious effects of victimisation upon the health and well-being of those who have been harmed.
References