Crime victims and chronic coping failure: theoretical and empirical underpinning of a 2 x 2 – model of C-PTSD subtypes

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4 C-PTSD subtypes: wider context

• Model highlights *differences* among traumatized victims, exposed to *single incidents* and suggests 4 subtypes:
  – (1) Explosive versus (2) panic syndrome, and
  – (3) Helplessness vs. (4) embitterment syndrome

• However (re. chronic stressor): PTSD is a risk factor for repeat victimization (posttraumatic cycle in domestic violence)
• Most crime victims are resilient, in the sense that they do not develop chronic coping problems
• A substantial minority (< 10%) do exhibit chronic coping failure, including PTSD
• (single stressor condition). Coping failure typically reflects an interaction between susceptibility (victim attributes, prior to victimization) and nature of exposure
• Susceptibility includes: (1) pessimism / rumination/ looming cognitive style and (2) neuroticism / Negative emotionality
Commonalities across subtypes

- Nothwithstanding substantial differences, there are commonalities across subtypes, e.g.
- All victims qualify for DSM- cutoff-criteria (intrusion, avoidance, hyper arousal), and particularly
- Elevated *fear of crime* / persistent concerns over repeat victimization
- Perceptions of *unique vulnerability*, and
- Perceptions of *unique susceptibility* (lowered, relative to other peers, capacity to overcome negative consequences)
- (cognitive markers of chronic PTSD)
Evidence base:

- Total sample includes more than 3000 directly exposed crime victims
- A series of some 6 prospective studies, including (matched) controls, property- and person-directed interpersonal (domestic/ public) violence
- “Fresh victims”: majority of initial assessments were made at the day the incident took place (‘memory biases’); recruited via police stations
- Varied follow up intervals, incl. 1 wk, 2 wks, 1 month, 2ms, 4ms, 8ms, 10 ms; or 1, 3, 6, 9 months /varied measures: STAXI, ARS,DAR (anger); WAS or PTCI (beliefs)
- Robust design: initial (panel) study included pre-victimization assessments of wellbeing, perceived vulnerability, hardiness
## 2 by 2 model of C-PTSD

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<th>Pathway to Disorder / mechanism</th>
<th>Internalizing Symptomatology</th>
<th>Externalizing Symptomatology</th>
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| Cognitive route ("cognitive validation")
PTSD embedded in a depressive disorder; “hopelessness syndrome” | HELPLESSNESS SYNDROME | EMBITTERMENT SYNDROME |
| Emotional route ("peritraumatic escalation")
PTSD embedded in “neurotic” disorder; False alarm syndrome | PANIC SYNDROME | EXPLOSIVE SYNDROME |
Internalizing versus externalizing symptomatology

Internalizing symptoms

• Internal causal attribution, particularly character attribution;
• Self as easy target – bias
• State anxiety
• Identification with the aggressor (Stockholm in DV; anxious attachment)
• Propensity to panic in response to subjective danger signals (SAM-based conditioned startle)
• Avoidance / submissive behavior

Externalizing symptoms

• External causal attribution
• Hostility bias
• State anger / anger rumination
• Anger-based rejection of the perp.; revenge
• Propensity to explode
• Impulsive aggression
Two basic dimensions (1):

• PTSD is *predominantly* associated with I or E symptomatology.

• However: this does not imply that their correlation is nil.

• I-E oscillation ("waxing & waning"), posing a further diagnostic challenge, needs further empirical scrutiny.

• Enhanced anger may be due to:
  – Direct confrontation with perp. As part of an identification procedure; or
  – Engaging in VIS/ VSO ("Teeven-suggestion") during trial participation
  – Massmedia "anger wave"(terrorism)
2nd dimension: 2 pathways / pathogenic mechanism

• Cognitive pathway: Cognitive validation of premorbid relatively negative beliefs about self, others, and the world (versus Janoff-Bulman: “shattered assumptions”- model): a dysregulation of the “cognitive system”
  – “cognition” precedes emotional (and behavioral) consequences (appraisal hypothesis); cognition (hostility), emotion (anger), & behavior (violence) are alw. correlated

• Emotional pathway: peritraumatic escalation results in a dysregulation of the alarm (fight-flight) system (“emotion” precedes cognition)
False alarm PTSDs

Cascade of cognitive consequences:
*Shattered illusions* - model / depleted resilience
(the world is safe, *but not always*)

**Peritraumatic Escalation:**
*Extreme emotions,*
experienced in the context of
*EmergencyResponse-failure, incl.*
- Tonic Immobility
- Blind anger / rage
- *(dissociative experiences)*

**Dysregulation of the Alarm (fight/flight) System:**
- Hypervigilance
- Propensity to panic,
- Propensity to explode in response to subjective, imaginary danger signals

Brewin-hypothesis:
Implicit storage in **SAM**

Conditioned Startle
Subtyping: Implications

- Subtyping is not merely an academic issue: Has both practical and more fundamental implications
- Bottomline: all subtypes cause clinically significant distress for crime victims (geen verschillen in gerapporteerde lijdensdruk; testable hypothesis)
- It is not my intention to trivialize PTSD embedded in a depressive disorder (e.g Jolink)

“Ik breek liever elk bot in mijn lichaam dan dat ik nog 1 minuut depressief ben”

Practical implication:

- Substantial international evidence base that suggests that PTSD is a risk factor for repeat victimization (e.g. Winkel & Baldry, 2013)
  - PTSD associated with (cognitive, emotional, behavioral) externalizing symptomatology is a relatively stronger risk factor (Winkel & Baldry, 2013, 219 – 236)

- Explosive Syndrome (ES) is a prominent risk factor for re-involvement in domestic (Kuijpers et al, JTS, 2013) and public interpersonal violence (Kunst et al., V&V, 2013); victim violence (ES behavioral outcome): substantial mediator
Fundamental implication

• Externalizing symptomatology has been understudied as an important treatment target of trauma-focused protocols (EMDR= promising)
  – Protocols are not effective for all (next slide)
• Rapid international proliferation of Victim Support services (incl. Slachtofferhulp Nederland)
• Victims who suffer from false alarm syndromes are:
  – Severely disordered (‘psychotic features’; vgl. v.d.Brink),
  – in need of professional psychological (vgl “boundaries”, Kahn)
  – And catharsis focused treatment
Anger treatment protocols: effect sizes (del Vechio & O’Leary)

- Binomial effect size display of each treatment group
- Condition Success (%) Failure (%)
  - CBT 66 34
  - Cognitive T 69 31
  - Relaxation T 70 30
  - Other T 65 35
Catharsis (?!)

• Catharsis is a controversial issue


• **It goes way beyond** volunteer victim support, mere tea and sympathy, or offering cognitive therapy

• EMDR-based **Anger and Retaliatiion protocol**, developed by Herman Veerbeek is
  
  – A promising option for treating explosive disorder, and

  – in need of RCT-based evidence
Cathartic treatments promoting the value of an emotional release, which are still frequently used, are noticeably absent from this analysis. The authors were unable to locate any controlled outcome studies on the effects of cathartic treatments, a finding also cited in Tafrate (1995). However, research to date suggests that cathartic treatments are likely to be ineffective and may even encourage individuals to engage in aggressive acts. For example, Bushman et al. (2001) found that subjects who were induced to believe that catharsis was beneficial responded more aggressively to insulting criticism than did controls. It may be that cathartic treatments fail to provide skills needed to deal with new situations or self-control strategies that may be useful for high anger individuals who display aggression. While many have criticized cathartic treatments (e.g., Tavris, 1989), certain types of anger suppression problems of adults may require teaching people some appropriate means of expressing disappointment, concern, and even irritation. Theories of catharsis suggest that it allows for the “venting” of anger for those who tend to hold anger in. However, how and when the venting takes place must be considered to ensure that anger suppression problems do not become anger expression problems.

Some references...


