Older Victims of Community Crime:

Psychological Impact and Coping

Thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

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Supervised by: Prof. Marc Serfaty, Prof. Jo Billings, and Prof. Gerard Leavey

Declaration

I, Jessica Satchell, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature: [redacted] Date: 23rd November 2023

Abstract

Background

With population ageing and sociopolitical changes, crime victimisation is increasing in older adults, but understanding of the psychological impact of community crime in this group remains limited.

Study One

I systematically reviewed and quality-appraised the existing global literature on psychological impact and interventions in older victims. Searching 23,402 records yielded just 21 studies. Studies were disparate, but consistently reported adverse sequelae including anxiety, depression, post-traumatic stress, humiliation, self-blame, and behavioural changes. Only feasibility interventions have been published, suggesting further research on this population is needed.

Study Two

I conducted semi-structured interviews, using life-course narrative, to explore how early-life experiences shaped impact and coping in 27 older victims. I inductively analysed these interviews using thematic analysis and developed two key themes: 'childhood sense of safety', and 'beliefs and values'. These shaped how older victims perceive their crime, which influenced coping. I considered how this applied to the wider literature in a conceptual framework to guide therapeutic practice.

Study Three

Using mixed-methods, I investigated safety-seeking behaviours in older victims and whether they may be associated with continued distress. I designed a novel patient-reported measure, pre-tested in N = 31 older victims. I then collected data on safety-seeking behaviours and psychological distress in N = 100 older victims. I analysed data using inductive thematic analysis, logistic regression, and unique variable analysis. Older victims reported wide-ranging behaviours: some highly restrictive, others may help maintain independence. An increase in avoidance was most strongly associated with continued distress. Preliminary evaluation found my measure was acceptable, comprehensive, detected individual behaviours and common themes, and appears promising for research and clinical practice.

Conclusions

The psychological impact of community-crime in older victims varies, but the consequences for health, independence, and quality-of-life can be severe. Clarifying individual coping and targeting interventions to those in distress is crucial for improving support.

Impact Statement

1. New Resources

My qualitative findings informed a conceptual framework of possible pathways between life-experiences and healthy or dysfunctional coping in older victims. This explains how seemingly contradictory coping theories may be reconciled. This visual aid may be useful to professionals new to the field, and it responds to calls for research using the life-course perspective in older adults (UN, 2021).

I also developed the first patient-reported measure of safety-seeking behaviours, which offers a new approach to assessment and targets the lack of validity in existing tools. Although tested in older victims, I designed this to be applicable to any stressful event. Given the importance of safety-seeking behaviours to cognitive-behavioural theory and therapy, improved assessment has long-been needed (Telch & Lancaster, 2012). My measure may be useful to researchers, clinicians, and it contributes to the wider literature.

2. Training Professionals

My findings on psychological impact in older victims informed a training package for police officers, which I co-facilitated at Charing Cross Police Station. I also presented on safety-seeking behaviours during a training day for Mind therapists on adapted cognitive-behavioural therapy for older victims.

3. Further Research

My findings that older victims of hate crime felt let down by the police response informed three grant applications, which I contributed to as a co-applicant. This included the MRC Public Health Intervention Development (PHIND) fund to develop manualised therapy for hate crime victims aged 18 and over, and the NIHR-PHR programme to collaborate with the police to evaluate manualised therapy using single-case experimental design. We were subsequently awarded £2,000 by the NIHR-BRC for Public and Patient Involvement (PPI) focus groups with hate crime victims to further develop our grant applications.

My thesis informed four MSc projects, which I co-supervised: 1) A systematic review on psychological impact for hate crime victims aged 18 and over (in preparation for *Trauma, Violence & Abuse*), 2) A systematic review of interventions for crime victims aged 18 and over (submitted to *Biological Psychiatry*), 3) A qualitative study of older victims' perspectives of police response to their crime report (submitted to *Policing: Policy and Practice*), 4) A Delphi study on how to conduct mental health research with hate crime victims, involving national experts from the police, charities, public figures, academics, policy-makers, and NGOs (in preparation for *PLOS One*). The Delphi study enabled us to develop relationships with the charity StopHate UK and academics, who then joined as co-applicants on the NIHR-PHR grant.

4. Policy

I shared my findings on the impact of crime in older victims with Clare Waxman, the Victims' Commissioner for London, in November 2021. She was seeking evidence for her Ending Violence Against Women and Girls campaign. I also helped write a letter to the

Ministry of Justice as part of a consortium on the needs of older victims. My findings on individual coping also challenged acceptance of the use of the Cambridge High Harm Index, a measure of crime severity used by police forces nationwide, as it does not take individual impact into account.

UCL Research Paper Declaration Forms

1. My systematic review has been published in:

Satchell, J., Craston, T., Drennan, V., Billings., J., & Serfaty., M. (2022). Psychological Distress and Interventions for Older Victims of Crime: A Systematic Review. *Trauma, Violence, and Abuse, 24(5),* 3493-3512.

What is the title of the manuscript?

Psychological Distress and Interventions for Older Victims of Crime: A Systematic Review

Please include a link to or doi for the work

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Where was the work published?

Trauma, Violence & Abuse

Who published the work? (e.g. OUP)

Sage Journals

When was the work published?

3rd November 2022

List the manuscript's authors in the order they appear on the publication

Jessica Satchell, Tabitha Craston, Vari M Drennan, Jo Billings & Marc Serfaty

Was the work peer reviewed?

Yes

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https://eprints.kingston.ac.uk/id/eprint/52439/1/Drennan-V-52439-AAM.pdf

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2. Part of my qualitative study has been published in:

Satchell, J., Dalrymple, N., Leavey, G., & Serfaty, M. (2023). "If We Don't Forgive, It's Like Holding on to Them": A Qualitative Study of Religious and Spiritual Coping on Psychological Recovery in Older Crime Victims. *Psychological Trauma: Theory, Research, Practice and Policy.* Advance online publication.

What is the title of the manuscript?

"If We Don't Forgive, It's Like Holding on to Them": A Qualitative Study of Religious and Spiritual Coping on Psychological Recovery in Older Crime Victims

Please include a link to or doi for the work

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Where was the work published?

Psychological Trauma: Theory, Research, Practice, and Policy.

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APA

When was the work published?

February 2023

List the manuscript's authors in the order they appear on the publication

Jessica Satchell, Nicola Dalrymple, Gerard Leavey, Marc Serfaty

Was the work peer reviewed?

Yes

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3. My mixed-methods study has been prepared for publication but has not yet been published:

What is the current title of the manuscript?

Safety-Seeking Behaviors and Psychological Distress in Older Victims of Community-Crime: A Cross-Sectional Study Using a Novel Patient-Reported Measure.

Has the manuscript been uploaded to a preprint server? (e.g. medRxiv; if 'Yes', please give a link or doi)

No

Where is the work intended to be published? (e.g. journal names)

Journal of Psychopathology and Clinical Science

List the manuscript's authors in the intended authorship order

Jessica Satchell, Gary Brown, Chris R. Brewin, Jo Billings, Gerry Leavey & Marc Serfaty

Stage of publication (e.g. in submission)

Submission planned for January 2023

For multi-authored work, please give a statement of contribution covering all authors (if single-author, please skip to section 4)

Jessica Satchell designed the study, designed and pre-tested the measure, collected the data, analysed the qualitative data, conducted the logistic regression, co-conducted the unique variable analysis, and wrote the manuscript. Dr Gary Brown advised on the statistical analysis plan and supported the unique variable analysis. Chris Brewin advised on the measure design and interpretation of findings. Jo Billings and Marc Serfaty provided feedback on the measure design and supervised the study. All authors read and provided feedback on the manuscript.

In which chapter(s) of your thesis can this material be found?

Part IV: Study III

1. **e-Signatures confirming that the information above is accurate** (this form should be co-signed by the supervisor/ senior author unless this is not appropriate, e.g. if the paper was a single-author work)

   Candidate: [redacted]

   Date: 17th November 2023

   Supervisor/ Senior Author: [redacted]

   Date: 17th November 2023

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I especially wish to thank my primary supervisor, Prof Marc Serfaty, who offered me this opportunity and championed my vision throughout. His generosity with his time and ongoing mentorship developed me into the researcher that I am today. I also could not have completed my thesis without the expertise, insightful feedback, and kind words of encouragement from my secondary supervisors, Prof Jo Billings and Prof Gerry Leavey.

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A huge thank you goes to the MSc students who assisted me with transcription, organising research visits, sending letters, acting as secondary reviewers, and collaborating on papers including: Tabitha Craston, Nicola Dalrymple, Georgia West, Dylan Peters, Estella Lumer, Amanda Lim, Athena Echave, and Ayeda Nadeem.

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Finally, a very special thank you to the participants who so generously gave up their time to support my research and to whom my thesis is dedicated.

Contents

Contents of Tables and Figures

Summary of Abbreviations

ACT	Acceptance and Commitment Therapy	NIHR-PHR	National Institute Health Research Public Health Research
APA	American Psychological Association	ONS	Office for National Statistics
BACP	British Association for Counselling and Psychotherapy	PHIND	Public Health Intervention Development
CASP	Critical Appraisal Skills Programme	PHQ-2	Physical Health Questionnaire 2-item
CBT	Cognitive behavioural therapy	PILOTS	Published International Literature on Traumatic Stress
CENTRAL	The Cochrane Central Register of Controlled Trials	PPG	Positive Practice Guidelines
CINAHL	Cumulative Index for Nursing and Allied Health Literature	PPI	Public and Patient Involvement
CRIS	Crime Reporting Information System	PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
CSEW	Crime Survey for England and Wales	PRSBM	Patient-Reported Safety-Seeking Behaviour Measure
DBS	Disclosure and Barring Service	PTSD	Post-traumatic stress disorder
DSM	Diagnostic and Statistical Manual	RCT	Randomised controlled trial
FDA	Food and Drug Administration	REC	Research Ethics Committee
GAD-2	Generalised Anxiety Disorder 2-item	SNT	Safer Neighbourhood Team
GCP	Good Clinical Practice	TMG	Trial Management Group
GDPR	General Data Protection Regulation	UVA	Unique Variable Analysis
GHQ	General Health Questionnaire	UN	United Nations
HMICFRS	His Majesty's Inspectorate of Constabulary and Fire and Rescue Services	UK	United Kingdom
ISRCTN	International Standard Randomised Controlled Trial Number	UCL	University College London
MMAT	Mixed-Methods Appraisal Tool	VIP	Victim Improvement Package
MPS	Metropolitan Police Service	VIP TMG	Victim Improvement Package Trial Management Group
NHS	National Health Service	VS	Victim Support
NIHR	National Institute Health Research	WHO	World Health Organisation

Part I: Background

Chapter 1: Thesis Scope

Supporting older victims of community crime is an issue of mounting social concern with population ageing (Burnes et al., 2017; HMICFRS, 2019; Muhammad et al., 2021b; Qin & Yan, 2018). In the UK, nearly one in five (18.6%) citizens are now aged 65 or over and this is forecast to increase to 22% by 2032 (Office for National Statistics; ONS, 2023e). An estimated 26,541 community crimes were reported by older victims between 2022 to 2023 in London alone (MPS Personal Communication, 3rd August 2023) and, as 60-70% of crimes go unreported (Buil-Gil et al., 2021), the true number of older victims may be even higher. Older adults may be at increased risk of particular crimes, such as fraud and distraction burglary (Laycock, 2020), which increased by 37% during Covid-19 (ONS, 2022a). With current high inflation and the rising cost-of-living (International Monetary Fund, 2023), there are further concerns that crime may increase (Mayor-of-London, 2023a).

Many older victims cope well after a crime, but the consequences for others can be debilitating (HMICFRS, 2019; Thornton et al., 2003). Burglary and fraud in older victims are both associated with accelerated mortality (Burnett et al., 2016; Donaldson, 2003; Thornton et al., 2003). Older victims of interpersonal violence have been found to be at increased risk of nursing home placement (Lachs et al., 2006) and to have more severe scores on post-traumatic stress measures than older victims of motor vehicle accidents (Brunet et al., 2013). Depression attributed to victimisation in transgender older victims was found to have an even bigger health impact than well-established risks including smoking and obesity (Fredriksen-Goldsen et al., 2014). Chronic symptoms of psychological distress have been identified in 28% of older victims of different crime

types (M. Serfaty et al., 2016), which is considerably higher than rates of depression (7%) and anxiety (4%) in older people globally (The World Health Organisation, 2017).

There is growing recognition that the impact of crime should be considered a public health concern (Burnes et al., 2017; Middleton, 1998; Tan & Haining, 2016). However, a formal inspectorate of policing practices in England and Wales found that the police have only a superficial understanding of the needs of older victims and are underprepared for the growing challenges of supporting this population (HMICFRS, 2019). Meanwhile, a study of N = 680 older victims who had been identified by the police as psychologically distressed, and given letters signposting them to their GP, found that only 4% had received support when followed-up three months later (Serfaty et al., in prep). Older victims were often reluctant to seek help for psychological distress, but of those who did, GPs were poorly informed on how to support them. Taken together, more needs to be done to support older victims (Commissioner for Older People for Northern Ireland; COPNI, 2023).

1.1 Thesis Overview

My thesis is part of a wider programme of research aimed at understanding psychological impact and support for older victims of community crime. I completed my PhD part-time whilst working on the Victim Improvement Package (VIP) trial, initially as the research assistant and then as the trial manager. This presented the opportunity to embed data collection for my PhD within its framework. The VIP Trial is described in Chapter 2, but briefly, it aims to: 1) partner with the Metropolitan Police Service to identify older victims suffering psychological distress after a community crime, 2) investigate predictors of continued distress, 3) understand help-seeking and service

utilisation, and 4) test the clinical and cost effectiveness of adapted cognitive-behavioural therapy for treating continued psychological distress (Serfaty et al., 2020).

The VIP Trial was guided by Goldberg's Filter Model, which suggests that to improve the health of a population, it is necessary to: 1) increase awareness of impact, 2) improve case detection, 3) increase referrals to healthcare services, and 4) improve treatment (Goldberg & Huxley, 1980). As the VIP Trial targeted case detection, service uptake, and treatment improvement, this informed my decision to focus on psychological impact, but Goldberg's Filter Model was not a guiding theory for my thesis.

A statement of my contribution and declaration of support received for my thesis is in Appendix 1.

1.1.2 Thesis Aims

I aimed to strengthen knowledge on the psychological impact of older victims of community crime by:

1) Conducting a systematic narrative review and quality appraisal of the global literature on psychological impact and interventions in older victims (Satchell et al., 2022). The purpose of my review was to establish the strength of existing research and identify evidence gaps that my thesis could target.

2) Conducting a qualitative study exploring how life experiences shape how older victims make sense of their crime and cope (Satchell et al., 2023). This was to further understand psychological impact and explore individual differences in coping, which my systematic review had found was an evidence gap.

3) Conducting a mixed-methods study to investigate whether safety-seeking behaviours are associated with continued psychological distress in older victims. To do this, I aimed to design, pre-test, and preliminary evaluate a novel patient-reported

measure of safety-seeking behaviours. The development and testing of a specific patient-reported measure built upon the findings of my systematic review and qualitative study, which found evidence of older victims changing their behaviour after a crime, but that the association with continued distress had not been investigated.

1.2 Defining Older Victims

There is no agreed definition of 'older victims' in the Criminal Justice System (HMICFRS, 2019) and a systematic review of 84 studies on ageing found that minimum ages varied from 50 to 90 (Cosco et al., 2014). I therefore selected the lowest minimum age of 50 and over for my systematic review as it is recommended that reviews are over-inclusive to capture all relevant literature (Higgins et al., 2023). However, I defined older victims as 65 and over for my empirical studies, consistent with the VIP Trial inclusion criteria (Chapter 2). This age range was selected by the VIP Trial as earlier feasibility work found that psychological distress was greater in older victims aged 65 or over compared to older victims aged 55 to 64, suggesting that 65 is the most appropriate minimum age for older victim research (M. Serfaty et al., 2016).

Definitions of criminal victimisation are also debated (Janssen et al., 2020). Whilst it broadly refers to harm caused by another person's culpable actions (e.g., physical injury, material loss) (Von Hirsch & Jareborg, 1991), some interpret this as any recipient regardless of consequences whilst others apply it only to those who feel affected (Havers et al., 2023; Janssen et al., 2020). As definitions vary, the VIP Trial identified older victims through crime reports to the police (M. Serfaty et al., 2016). However, as not all crimes are reported (Buil-Gil et al., 2021), I adopted a broader definition in my systematic review and included any study that stated it was about older victims and met all other eligibility criteria.

1.3 Defining Community Crime

The World Health Organisation (WHO) Violence Prevention Alliance presents a typology, which – although specific to violence - offers a useful distinction of the different contexts within which crime may occur (World Health Organisation, 2023). Three main types of violence are described according to victim-perpetrator relationship: self-directed, interpersonal, and collective ('political') violence. Interpersonal violence is sub-divided into community and family/partner. Community violence is perpetrated by acquaintances or strangers (e.g., youth violence, stranger assault, property damage, workplace violence) whilst family/partner violence includes child maltreatment, domestic violence, and carer abuse. I adopted this same distinction in my thesis but extended it to crime more broadly, meaning my focus was on older victims of crimes perpetrated by strangers or acquaintances ('community crime'). My systematic review included all studies on psychological impact in older victims meeting this definition. However, sexual violence was excluded from my empirical studies as pre-determined by the VIP Trial because the intervention was not considered suitable for this group (Serfaty et al., 2020). A complete list of crimes eligible for inclusion in my thesis is in Appendix 2 (for definitions, see: MPS (2023a)).

My research is distinct from elder abuse, which is a term used inconsistently by researchers (Bowes, 2018; Mysyuk et al., 2013). Some studies define elder abuse as a crime against an older person regardless of context or perpetrator (Payne et al., 1999; Weissberger et al., 2020). However, The WHO defines elder abuse as single or repeated acts, or failure to act, within any relationship where there is an expectation of trust (WHO, 2018). Therefore, even if a carer is meeting an older person for the first time, the expectation of trust differentiates them from 'strangers or acquaintances' in the

community crime definition. I focused on community crime in older victims because this has been neglected in research. For recent reviews on elder abuse, see: (Ballentine, 2023; Roberto & Hoyt, 2021; Yunus et al., 2019).

1.4 Defining Psychological Impact and Psychological Distress

1.4.1. Psychological Impact

As I aimed to understand the psychological impact of community crime in older victims, I broadly defined this as any emotional or behavioural response (Ridner, 2004) attributed to the crime. I discuss my findings on psychological impact throughout my thesis.

1.4.2 Psychological Distress

My research also focused on a particular aspect of psychological impact: continued psychological distress.

Psychological distress is defined as emotional suffering after an identifiable adverse event, characterised by symptoms of depression and anxiety (Drapeau et al., 2012; Mirowsky & Ross, 2003; Wheaton, 2007). Depression is an absence of positive emotions and loss of interest or enjoyment in ordinary activities most of the day, nearly every day (NICE, 2022). Symptoms may include low mood, impaired concentration, physical inactivity, fatigue, feeling worthless, guilt, suicidal ideation, or changes in appetite, sleep or sex drive (DSM-5-TR; American Psychiatric American Psychiatric Association, 2022). Anxiety is defined as excessive worry that is difficult to control, with symptoms including restlessness, feeling on edge, fatigue, irritability, muscle tenson, and difficulties falling or staying asleep (DSM-5-TR; American Psychiatric American

Psychiatric Association, 2022). I measured psychological distress using screening tools collected for the VIP Trial, described in Chapter 2.

I defined psychological distress as continued if symptoms were still present three months after the index crime. Initial negative reactions to stressful events are common and not necessarily a mental health concern (Horwitz, 2007), whereas prolonged symptoms may indicate an adjustment disorder (APA, 2022). Symptom persistence at three months has been found to be 2.7 times more likely to meet diagnostic criteria for severe psychiatric disorders, such as post-traumatic stress disorder, major depression, or generalised anxiety (O'Donnell et al., 2019; O'Donnell et al., 2016). Three months has therefore been recommended as an appropriate time for intervention as it allows for natural recovery without prolonging suffering (McNally et al., 2003).

1.4.3. A Comment on Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder (PTSD) consists of intrusive symptoms, avoidance, negative mood, and reactivity triggered by a threatening event (DSM-5-TR; American Psychiatric American Psychiatric Association, 2022). However, I focused on psychological distress rather than PTSD specifically, for several reasons.

Firstly, psychological distress fulfils partial criteria for PTSD diagnosis (DSM-V-R; American Psychiatric American Psychiatric Association, 2022). This means that not all distressed individuals will have PTSD, whereas all individuals with PTSD will be distressed.

Secondly, PTSD may be challenging to diagnose in older victims, as diagnostic manuals (e.g., DSM-V-TR, ICD-11; APA, 2022; WHO, 2021) stipulate that incidents must be outside the range of normal human experience ('The Criterion A Controversy'; Brewin et al., 2009; Jongedijk et al., 2022). It is unclear whether community crimes qualify under

this definition, especially 'high volume, low severity' crimes such as petty theft (Satchell et al., 2022).

Psychological distress was therefore more appropriate for my thesis as it encapsulated a broader range of negative emotional responding after any community crime.

1.5 Methodological Context

I used mixed-methods in my thesis, which involves using both quantitative and qualitative techniques (Johnson et al., 2007). Mixed-methods are considered well-suited to answering research questions because the strengths of one can offset the limitations of the other (Regnault et al., 2017). They also achieve a more holistic understanding by considering the problem from multiple perspectives (Johnson et al., 2007). Despite their benefits, mixed-methods have been under-utilised in healthcare because they are resource-intensive and require researchers to be proficient in both skillsets (Wasti et al., 2022).

1.5.1 Triangulation

My systematic review included quantitative and qualitative studies and I critiqued them according to their methodology.

My qualitative study used only qualitative methods, including purposive sampling, interviews, and thematic analysis (further described in Chapter 10).

My mixed-methods study combined techniques in a novel measure, which asked participants to describe a behaviour (qualitative) and rate this on Likert scales (quantitative). I analysed the data using corresponding analytical approaches. My sampling technique was probability (quantitative), to reduce bias from the quantitative

analysis (Basti & Madadizadeh, 2021). However, I explained how this approach was also suitable for the qualitative analysis within the context of the study (Chapter 13).

My studies jointly informed my conclusions, which I outlined in the final discussion (Chapter 19).

1.5.2 Philosophical Perspective

Philosophical assumptions inform methodological decisions so acknowledging these in the reporting of research is important (Williams, 2020). I provide a brief summary of the relevant epistemological perspectives that underpin research here, but for a fuller discussion, see: (Meadows, 2022; Mukumbang, 2023; Petty et al., 2012; Regnault et al., 2017; Williams, 2020).

Quantitative research is grounded within Positivist/Post-Positivist epistemology (Petty et al., 2012). This assumes there is just one reality ('truth') which, if measured robustly, can produce objective knowledge ('facts') (Petty et al., 2012). Researchers using quantitative methods aim to observe and measure evidence following the principles used in the natural sciences (The Scientific Method; Popper, 1968; Williams, 2020). There is a preference for broad data collection across many individuals to enable inferences about populations (Lyon et al., 2017; Petty et al., 2012). However, the complexity and intangibility of human behaviour makes reproducibility in psychology challenging ('The Replication Crisis'; Cohen et al., 2018; Hubbard, 2015; Open Science, 2015). This approach has also been criticised for depersonalising humans by failing to account for their unique ability to interpret their experiences (Williams, 2020).

Qualitative research is grounded within Interpretivist/Constructivist epistemologies (Petty et al., 2012). This assumes there are multiple realities, which have been socially constructed through individual perception (Petty et al., 2012). Instead of

quantifying data, qualitative approaches broadly seek to understand patterns of meaning and context (Busetto et al., 2020). Studies are broad, evolve with the data, and the researcher's interpretation is integral (Petty et al., 2012). There is a preference for in-depth data collection from fewer individuals, which allows the voices of those who have experienced a particular health challenge to be heard (Prior et al., 2020). However, it is resource-intensive and cannot be generalised to populations (Ashworth et al., 2019).

The contradictory assumptions underlying quantitative and qualitative methods has led to long-standing debate as to whether they can be meaningfully mixed ('The Paradigm Wars'; Williams, 2020). However, in practice, people do have individual features and they share commonalities so psychologists need to find a way to honour both (Allport, 1961). A solution to this may be Critical Realism, which seeks to objectively measure 'the real social world' that has been shaped by individual perspectives, society, history, and culture (Mukumbang, 2023). Quantitative and qualitative approaches therefore need to work together to understand this social world, and their methodologies are considered a two-way process (Regnault et al., 2017; Timans et al., 2019). This alternative perspective is a relatively new approach to understanding knowledge (Wynn & Williams, 2012)

Few research studies acknowledge their philosophical assumptions (Mukumbang, 2023). I have discussed throughout my thesis how this failure to do so has created contradictions in the coping and safety-seeking behaviour literature, and I have suggested how this may be reconciled.

Chapter 2: Thesis Setting

My thesis was embedded within The Victim Improvement Package (VIP) Trial, the largest trial of older victims of community crime globally (Serfaty et al., 2020). The VIP Trial was funded by the National Institute for Health Research (NIHR) Public Health Research Programme (NIHR-PHR; 13/164/32) (ISRCTN: 16929670).

The VIP Trial's primary aim was to conduct a randomised controlled trial (RCT) testing the clinical and cost-effectiveness of adapted cognitive-behavioural therapy (CBT) for older victims aged 65 or over suffering continued psychological distress three months after a crime. This was in collaboration with the Metropolitan Police Service (MPS), who supported identification and screening, and the mental health charity, Mind, who delivered the intervention.

The VIP Trial's secondary aims were to investigate predictors of continued distress in older victims, the effectiveness of the police providing letters signposting older victims to their GP, and to understand barriers and facilitators of help-seeking. The VIP Trial followed on from a pilot study (HAVoC; M. Serfaty et al., 2016), which found that CBT appeared promising for treating continued psychological distress, and that home visits from police officers were more successful in engaging older victims in research (90.8%) than leaflets (4.8%), or telephone calls (36.8%) from the police or Victim Support.

Data collection for the VIP Trial has now been completed (N = 131) but analyses is still underway. Resource constraints within the MPS and the Covid-19 pandemic required the VIP Trial to adapt its methods on several occasions, but I have described only the methods relevant to my PhD here. For full details on changes to the VIP Trial see: (Serfaty et al., 2020; Serfaty et al., In prep.)

2.1 The VIP Trial Location

The VIP Trial – and my PhD - were conducted across nine North and East London boroughs selected based on crime rates, prevalence of older people, and Mind service capacity: Camden, Islington, Barnet, Enfield, Hackney, Haringey, Tower Hamlets, Newham, and Havering. Three additional boroughs (Waltham Forest, Redbridge, and Barking & Dagenham) were added to the VIP Trial after I had completed my PhD data collection.

2.2 The VIP Trial Design

The VIP trial consisted of three steps (Figure 1):

Step 1 (Screening)

Eligible older victims reporting a crime to the MPS were screened for psychological distress by police officers within a month of the crime using the Patient Health Questionnaire (PHQ-2) and Generalised Anxiety Disorder Questionnaire (GAD-2) (Kroenke et al., 2003; Kroenke et al., 2007) (described in Section 2.4).

Older victims were identified by the police through the MPS Crime Reporting Information System (CRIS), which allocated every eligible older victim a unique reference number. The CRIS system had been automated to notify the older victim's local police Safer Neighbourhood Team (SNT) that an eligible crime had been reported. SNT officers then completed home visits with the older victims to offer reassurance and practical advice, collect sociodemographic and screening data, and obtain consent to data share and for the VIP researchers to contact them. Participants who screened positive for psychological distress were also given signposting letters to take to their GP, which stated they had been a victim of crime and screened positive on the GAD-2/PHQ-2.

Step 2 (Rescreening)

Screen positive older victims who had consented to follow-up were rescreened three months later on the GAD-2 and PHQ-2 and asked if they had acted on the GP signposting letter. This step was conducted by VIP Trial researchers, including myself. Older victims who rescreened positive were assessed for their eligibility for the VIP Trial RCT and those meeting criteria were invited to participate in Step 3. A purposive subset of rescreen positive and negative older victims were invited to participate in qualitative interviews, which were arranged as separate visits.

Step 3 (RCT)

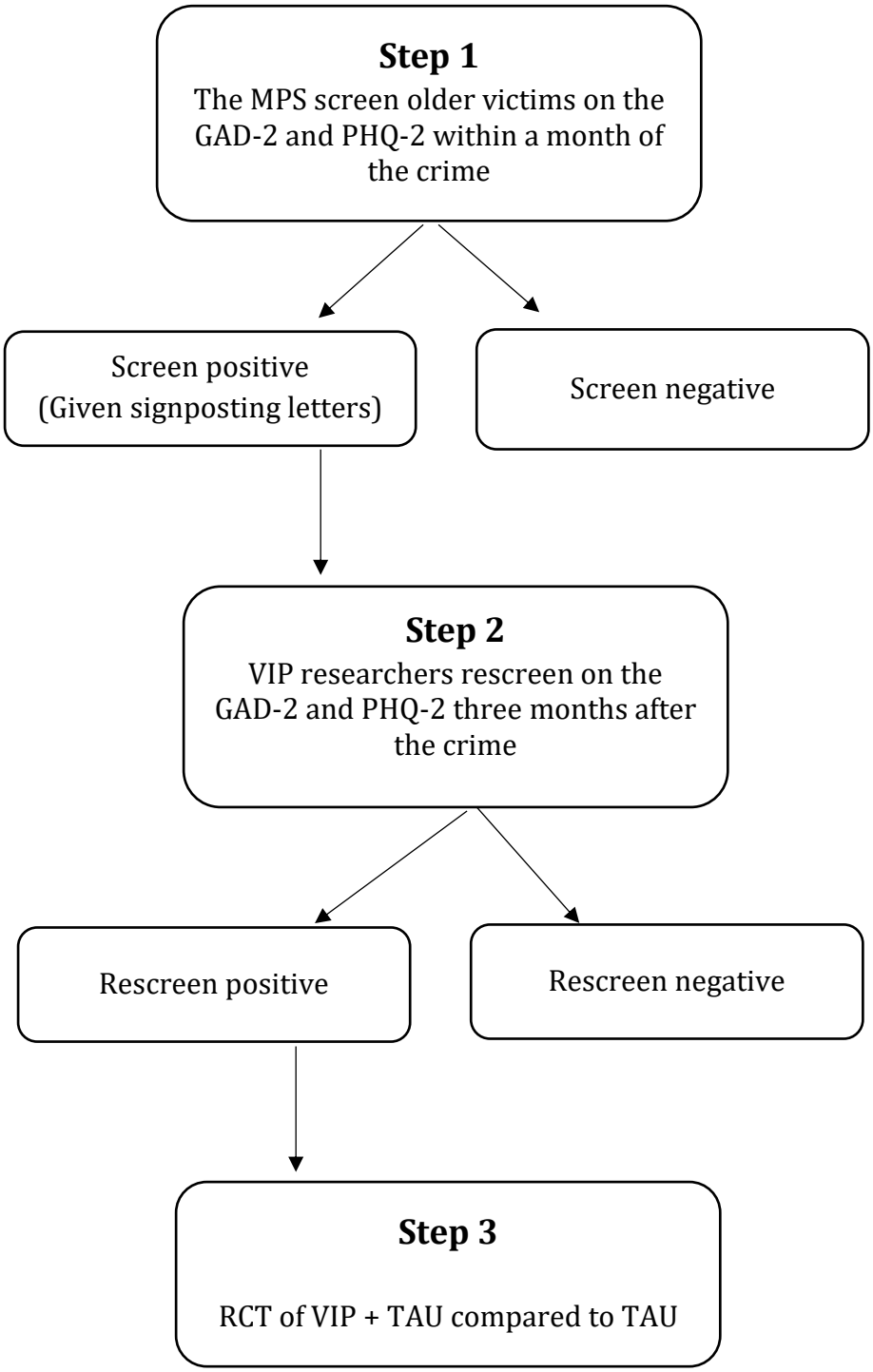
Eligible and consenting older victims were randomised into an RCT testing the clinical and cost-effectiveness of a manualised CBT-informed Victim Improvement Package plus treatment as usual (VIP+TAU) with a control group of treatment as usual only (TAU).

Cognitive Behavioural Therapy (CBT) is a talking therapy recommended for the treatment of depression and anxiety (NICE, 2020, 2022). It considers psychological problems to be rooted in unhelpful ways of thinking and behaving, and teaches individuals how to recognise and change these (APA, 2017a). The adapted VIP intervention applies the principles of CBT to the thinking and behavioural patterns that may be relevant to older crime victims (Serfaty et al., 2020; Serfaty et al., 2013). The efficacy of CBT in older adults is well-established (Werson et al., 2022) but only preliminary evidence currently exists for its use with older victims (Serfaty et al., 2016).

Older victims who had agreed to participate at Step 3 were re-visited by VIP Trial researchers a minimum of 48 hours later. Signed written consent was obtained and a battery of baseline measures completed, including the Beck Anxiety Inventory (Steer &

Beck, 1997), Beck Depression Inventory (Beck et al., 1996), the Mini-International Neuropsychiatric Interview (Sheehan et al., 1998), EuroQol-5 (Rabin & de Charro, 2001) and the Client Service Receipt Inventory (Curtis, 2008). Participants were followed-up three and six months later on the same measures by the VIP researchers who were blinded to group allocation.

Figure 1: Flowchart of The VIP Trial



2.3 Data Collection Method

Step 1 (police screening) and Step 3 (RCT) were completed as home visits. Step 2 (rescreening) was initially conducted as a home visit and then subsequently over the telephone. This was because increasing numbers at Step 3 meant it became infeasible to also travel to everyone at Step 2. Step 3 was prioritised for home visits because of the need to obtain signed written consent and because data collection would have been more burdensome for older victims over the telephone at Step 3 than at Step 2.

2.4 Measures

The VIP Trial collected sociodemographic data and screening data on the GAD-2 and PHQ-2 at Steps 1 and 2, which I also used for my PhD (Appendix 3).

Older victims were screened/rescreened using the GAD-2 and PHQ-2 because they are brief and simple, and therefore pragmatic for the police officers to use without requiring extensive training (Serfaty et al., 2020). Older victims were defined as screen positive in the VIP Trial if the scored 2 or more on the GAD-2 and/or 3 or more on the PHQ-2 and attributed this to the crime. They were defined as screen negative if they scored 1 or less on the GAD-2 and 2 or less on the PHQ-2, or if they scored more but attributed this to reasons other than the crime.

2.4.1 The Generalised Anxiety Disorder-2 (GAD-2)

The Generalised Anxiety Disorder-2 (GAD-2) is a rapid and reliable screening tool for the assessment of anxiety symptoms (Kroenke et al., 2007). The GAD-2 contains the first two-items of the GAD-7, which closely corresponds with the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV) (APA, 1994) criteria for generalised

anxiety disorder (Spitzer et al., 2006). These items, rated based on the preceding two weeks, are: 1) *Feeling nervous, anxious or on edge* and 2) *Not being able to stop or control worrying.* Each item is scored on a four-point Likert scale (0-3), which correspond to (not at all, several days, more than half the days, nearly every day). These scores are then added together to produce a total score out of 0 to 6. A cut-off score of 3 or more is indicative of anxiety in most populations but a lower cut-off of 2 or more has been recommended for older adults (Wild et al., 2014). A meta-analysis found that the GAD-2 has acceptable psychometric properties (Plummer et al., 2016). It has been validated in older adults (Wild et al., 2014) and it has previously been used in older crime victims (M. Serfaty et al., 2016).

2.4.2 The Patient Health Questionnaire-2 (PHQ-2)

The Patient Health Questionnaire-2 (PHQ-2) is a rapid and reliable screening tool for the assessment of depressive symptoms (Kroenke et al., 2003). The PHQ-2 is an abbreviated version of the PHQ-9, which closely corresponds with DSM-IV (APA, 1994) criteria for depression (Kroenke et al., 2001). This two-item measure assesses two core symptoms of depressive disorder, rated based on the preceding two weeks: 1) *Feeling down, depressed, or hopeless* and 2) *Little interest or pleasure in doing things.* Each item is scored on a four-point Likert scale (0-3), which correspond to (not at all, several days, more than half the days, nearly every day). These scores are then added together to produce a total score out of 0 to 6. A cut-off score of 3 or more indicative of depression. The PHQ-2 has been found to have excellent discriminant validity and acceptable sensitivity and specificity (Staples et al., 2019). Its use has been validated in older adults (Li et al., 2007) and it has previously been used in older crime victims (M. Serfaty et al., 2016).

2.4.3 Sociodemographic data

Sociodemographic data was collected by the police using a proforma including gender, age, ethnicity, crime reported, relationship status (single, married, divorced, cohabiting, widow/er, separated, other), living arrangement (owner/occupier, housing association, private rented, residential care home, nursing home, council rented, other), level of education (primary, secondary, higher), and occupation before retirement (free-text response). Older victims were also asked: has anyone been arrested in relation to the crime? (Yes/No); have you been a victim of any other crime in the previous 12 months? (Yes/No); has the crime affected your daily life? (Yes/No); have you previously suffered from depression or anxiety? (Yes/No). They were also asked how many social contacts they had had in the previous week (free-text response), and their sense of safety before and after the crime (very safe / safe / neither safe nor unsafe / unsafe / very unsafe).

I used aspects of the sociodemographic data to report on my sample characteristics and to test for confounding in my safety-seeking study. I did not otherwise explore sociodemographic characteristics on psychological impact in-depth as a study on the predictors of continued distress was underway by VIP Trial researchers elsewhere.

2.5 Ethics

The VIP Trial was approved by the University College London Research Ethics Committee (UCL REC) on the 17th March 2016 (6960/001) (Appendix 4.1). I submitted amendment requests to include my PhD studies within its existing procedures, which are described in Chapters 10 and 14 (Appendix 4.2-4.3). I have Enhanced Disclosure and Barring Service (DBS) clearance, and I completed training on research governance, data protection, research integrity, good clinical practice (GCP), and research ethics. I adhered

to guidance from the American Psychological Association (APA, 2017c), British Psychological Society (BPS, 2021), General Data Protection and Regulation (GDPR, 2016), and the Declaration of Helsinki (World Medical Association, 2013) throughout.

2.5.1 Consent

Signed written consent was obtained for all participants in my PhD and was embedded within the VIP Trial procedures (Appendix 5). Capacity to consent was presumed in line with the Mental Capacity Act (2005). Participants were informed of their right to withdraw or pause, to confidentiality, and data protection procedures were explained.

- At Step 1, older victims were provided with a participant information sheet by the police, who obtained consent to data share with UCL and for UCL to follow-up (Appendix 5.1-5.2).
- When Step 2 was completed as home visits, older victims were given an additional participant information sheet and consent was obtained by the VIP researchers (Appendix 5.3-5.4). When Step 2 was moved to telephone, an ethics amendment request was sent to UCL REC requesting permission to obtain consent for Step 2 data collection in the Step 1 consent form. This was approved by UCL REC on the 7th December 2018 (Appendix 4.4).
- At Step 3, older victims were provided with a further participant information sheet and signed written consent to participate in an RCT was obtained (Appendix 5.7-5.8).
- As my mixed-methods study was embedded within existing research visits, consent was obtained in line with these procedures. As my qualitative interviews were conducted as separate research visits, participants were

provided with an additional participant information sheet and signed written consent was obtained (Appendix 5.5-5.6).

2.5.2 Data Storage and Protection

The VIP Trial was registered with the Data Protection Office on the 26th February 2016. Participant data were pseudonymised using the unique reference number allocated by the police CRIS system at Step 1. It was not possible to fully anonymise the data because the VIP Trial researchers needed to be able to identify participants to complete follow-up.

Data collection was completed on paper and then transferred into an electronic tracking sheet, which also identified when a participant was due to be followed-up. The paper data and consent forms were securely stored in a locked unit at UCL. The electronic tracking sheet only contained participant ID numbers and was stored on the UCL *S drive*, which could only be accessed by authorised VIP researchers. Participant names and contact details were separately stored on Data Safe Haven, which has been certified to IS027001 information security standards and approved by the NHS Digital Governance Toolkit (NHS Digital, 2023). This ensured that the electronic participant data and linking information were not stored within the same system.

My qualitative interviews were recorded using an encrypted Dictaphone, which was saved by reference number. Identifying information including names and places were removed during transcription (e.g., "[participant's partner] said…"). Once transcription had been completed and checked, the audio files were deleted.

2.5.3 Further Considerations

Obtaining informed consent and ensuring participants are aware of their right to confidentiality and to pause or withdraw is standard practice in research with human participants (BPS, 2021).

Studies on negative events such as crime raise additional ethical considerations because they may be distressing to discuss (McGuire, 2009; Seedat et al., 2004). Researchers should therefore consider whether the benefits of the study to the individual or society outweigh the risks of causing distress or discomfort ('beneficence'; Tirone et al., 2014). Reviews of trauma studies suggest that although participants may become upset, they often find value and meaning in the research process (Schwerdtfeger & Nelson, 2008; Seedat et al., 2004; Tirone et al., 2014). For example, a large trauma-focused survey (N = 1174) reported that most participants found the experience of being involved in research positive despite the sensitive content (Newman et al., 1999). Not conducting research in this area may also do victims a disservice because it risks silencing them (Perôt et al., 2018) and limits knowledge on how to help (Becker-Blease & Freyd, 2006). Participants should therefore be able to decide for themselves whether they feel able to be invovled, and researchers should be engaged, non-judgemental, and empathetic so that participants feel comfortable sharing their experiences (Perôt et al., 2018).

Similarly, avoiding research with older adults because of their age is considered stigmatising and discriminatory, counter to guidelines on socially inclusive practice (Principle E of the Code of Ethics; APA, 2017b). There is a huge need for older adult research, given population ageing, to inform best practice in healthcare (Nature, 2021).

The recently published INCLUDE framework (Goodwin et al., 2023) therefore advises the following:

- There should be no upper age limit in older adult studies.
- Capacity to participate should be presumed and decisions otherwise made on an individual basis.
- Studies should clearly explain its relevance to health and wellbeing.
- Older adult experts and peers should advise on the research.
- Family and carers should have the opportunity to support their involvement.
- Researchers should offer flexibility around time and location.

In line with this, my studies had no upper age limit. Although cognitive impairment was an exclusion criterion for entry into the VIP Trial RCT, participants were not excluded from my thesis studies, where this presented. I consulted with academics in older age psychiatry at UCL and in the VIP Trial Management Group for their recommendations on conducting research with this group. I also consulted three older crime victims who were supporting the VIP Trial as part of Public and Patient Involvement (NIHR; INVOLVE, 2021). Family and carers were encouraged to support participants where available and I offered flexibility around time and loction of research visits. I believe I established good rapport with participants, who appeared comfortable discussing their experiences. I raised any concerns with my primary supervisor, who is a qualified psychiatrist. For one participant, I was advised to write to their GP with their consent. I further discuss ethical considerations in Chapters 10 and 14.

2.6 How My Thesis Was Embedded Within the VIP Trial

My thesis was predominantly embedded at Step 2 rescreening (three months post-crime), as this enabled me to examine continued psychological distress and coping. It

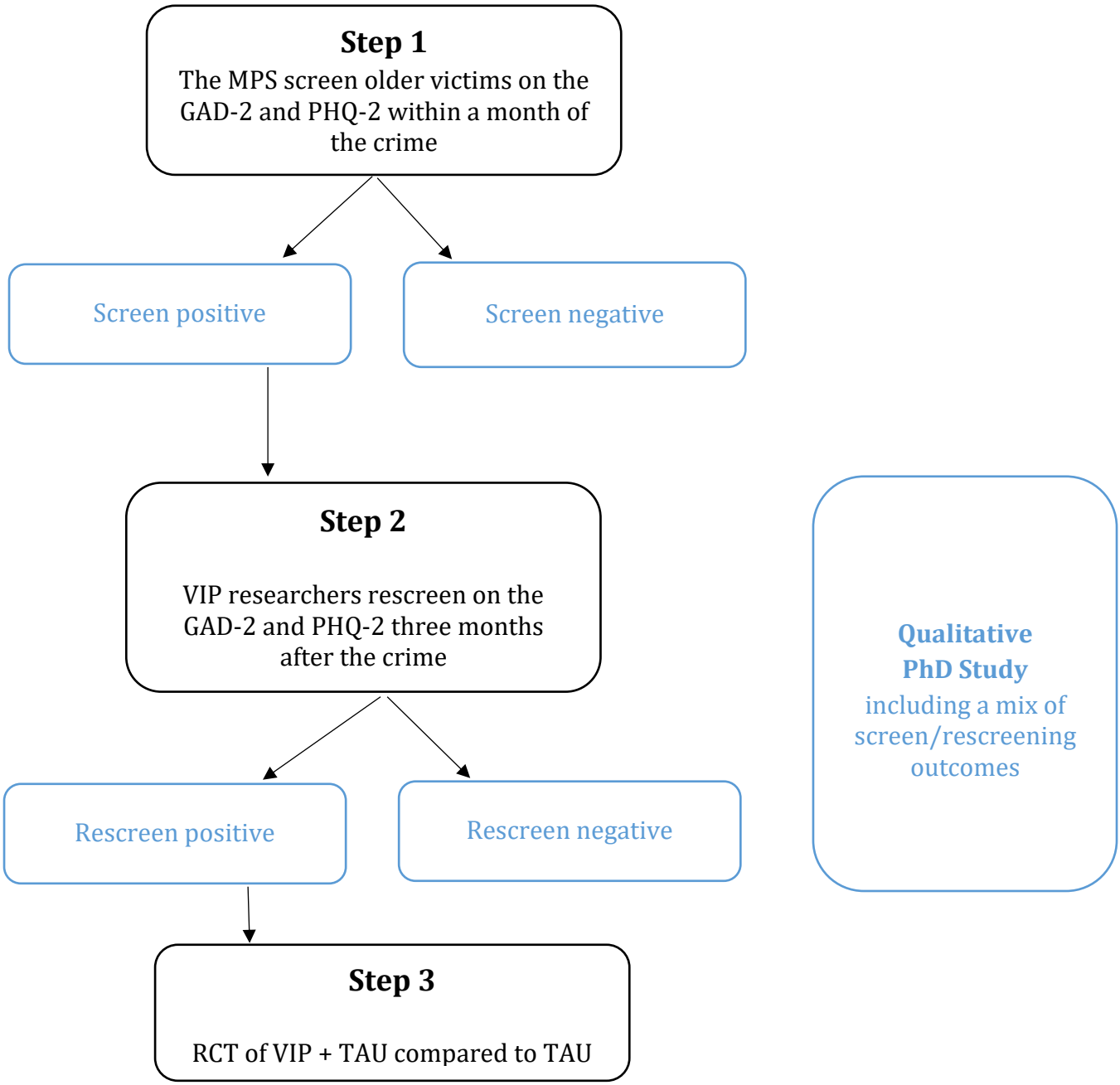
was not possible to collect additional data at Step 1 as data protection regulations required the MPS to do this, but I was able to use the screening and sociodemographic data which the police had collected. I also did not use Step 3 data as this was only available for the smaller sample involved in the RCT and I was blinded to group allocation.

A flowchart of my PhD studies within the VIP Trial framework are presented in Fig. 2 and Fig 3.

2.6.1 Qualitative Study

As I was completing interviews on help-seeking for the VIP Trial, I designed a topic guide which allowed the help-seeking study and my PhD study to be conducted simultaneously (Chapter 10). I identified and recruited most participants during Step 2 rescreening visits and arranged interviews as separate home visits. This had the advantage of establishing rapport before the interviews. As I aimed to achieve a diverse sample, I also purposively recruited a subset of Step 1 screen negative older victims for the qualitative interviews.

Figure 2: Flowchart of My Qualitative Study Within The VIP Trial

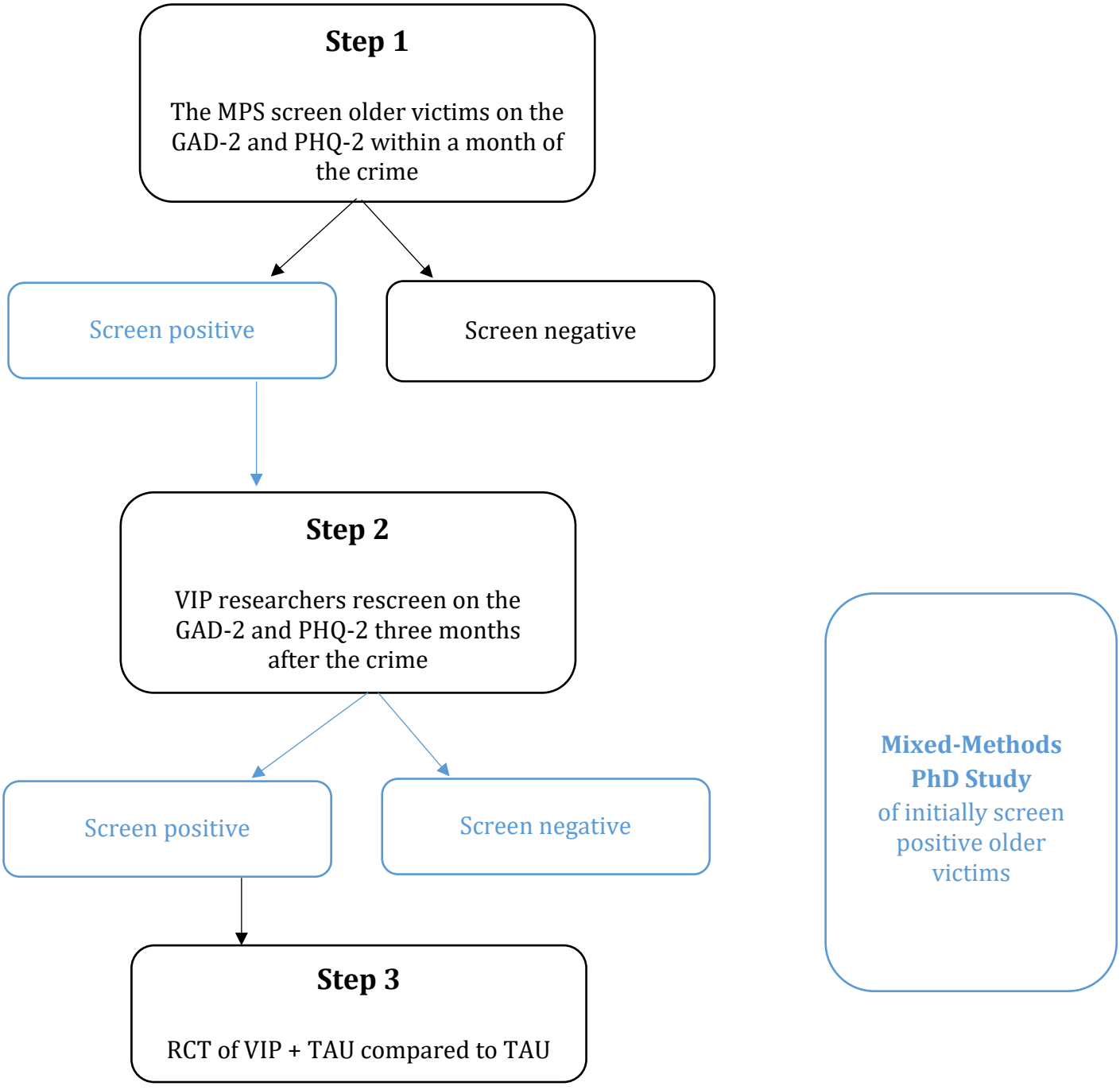


2.6.2 Mixed-Methods Study

As my mixed-methods study aimed to test whether safety-seeking behaviours were associated with continued psychological distress, only older victims who had initially screened positive at Step 1 were eligible to participate. I initially collected my data during

Step 2 but when this was moved to telephone, I then collected my data during baseline visits for Step 3. The implications of this for my research are considered in Chapters 14 and 18.

Figure 3: Flowchart of my Mixed-Methods Study Within The VIP Trial



Chapter 3: Background Literature

3.1 Crime, Victims, and Policing

3.1.1 Crime Rates

In England and Wales, The Office for National Statistics (ONS) combines data on police-reported crimes with an anonymous door-knock survey on unreported crimes (The Crime Survey for England and Wales; CSEW) to provide the most accurate available estimates of crime rates (ONS, 2023f).

Since the first report in 1981, yearly data shows that overall crime rates peaked in 1995 and then declined year-on-year until levelling off in 2019. In 2020 and 2021, crime rate estimations were complicated by the Covid-19 pandemic and corresponding tightening and easing of restrictions. In brief, overall crime fell due to sharp, short-term declines in specific crimes during lockdown including robbery, burglary, and violence (Langton et al., 2021; ONS, 2021). However, fraud, computer misuse, and domestic violence sharply increased (ONS, 2021). The easing of restrictions was then accompanied by brief resurgences of crime before settling back to pre-pandemic rates. As of 2022 and 2023, overall crime is comparable to 2019 rates and continues to be much lower than the peak in 1995 (ONS, 2022b, 2023a). Whilst there are concerns that crime may increase with the rising cost-of-living (International Monetary Fund, 2023; Mayor-of-London, 2023a), the data has not yet suggested this (ONS, 2023a).

Official data for Scotland and Northern Ireland are reported separately to reflect their different legal systems (Brown & Gordon, 2019). Whilst this limits crime estimates for the UK as a whole, both jurisdictions similarly report an overall downward trend since

peaking in the 1990s and early 2000s (NISRA, 2023; SGNS, 2023). However, despite these positive gains, significant numbers of crimes still occur throughout the country every year, and it remains a concerning issue (ONS, 2023c).

3.1.2 The Victims' Movement

In the 1970s and 1980s, the introduction of victims' surveys including the CSEW lead to an increased policy focus on victims that was coined 'The Victim's Movement' (Shapland & Hall, 2007). Services were commissioned, such as Victim Support in the UK, and international standards were developed (e.g., UN Declaration on the Rights of Victims of Crime and Abuse of Power) (Shapland & Hall, 2007). However, in the 1990s, policy interest in victims declined, and attention shifted to crime prevention at the population level (Shapland & Hall, 2007). There is now considerably more research on offenders than on victims (Green & Roberts, 2008; Lay et al., 2023).

Recent developments, however, suggest that The Victims' Movement may be returning:

- In 2017, the first Victims' Commissioner for London was appointed (Mayor-of-London, 2017)
- In 2020, the murder of George Floyd by police officers in the USA re-energised the Black Lives Matter movement, leading to widespread protests (BBC, 2020).
- In 2021, The Code of Practice for Victims of Crime was updated (Gov.uk, 2021a).
- In 2022, The Mayor's Police and Crime Plan for 2021-5 stated that improved support for victims was a key priority (Mayor-of-London, 2022).
- In 2023, the first ever Victims' Law was introduced (Gov.uk, 2023) and a National Economic Crime Victim Care Unit was rolled-out across all 43 police forces in England and Wales (City of London Police, 2023a). The Mayor-of-London, Sadiq

Khan, also announced a new £3 million annual investment package to improve support for victims during London's first Victim Summit (Mayor-of-London, 2023b), and calls for a specialist Victims' Hub were made (Mayor-of-London, 2023c).

Although this focus has been on crime victims broadly, specific recognition of older victims includes:

- In 2019, Her Majesty's Inspectorate acknowledged that the police had superficial knowledge on older victims and urgently needed to improve support (HMICFRS, 2019).
- In 2023, The Commissioner for Older People for Northern Ireland published a report calling on Criminal Justice Services to do more to support older victims (Commissioner for Older People for Northern Ireland; COPNI, 2023).

3.1.3 Public Confidence in Policing

Despite this growing recognition of victims' needs, victim satisfaction is declining and public confidence in policing is currently considered to be 'in crisis' (The Police The Police Foundation, 2022). Currently, less than 94% of reported crimes are resolved (ONS, 2023b). Serious concerns have especially been raised about the MPS due to police misconduct cases, evidence of institutional prejudice, and the murder of Sarah Everard by a serving officer (The Baroness Casey The Baroness Casey Review, 2023). Acknowledging an urgent need for reform, the MPS have recently published a Turnaround Plan, which includes a commitment to train the police in compassionate and evidence-based victim care (MPS, 2023b).

3.2 Older Victims of Community Crime

3.2.1. The Evidence Gap

Victim studies have disproportionately focused on younger adults (Bows, 2019a), who are often reported to be more affected by crime (ONS, 2023c; Payne, 2020). Although older adults make up a comparatively small proportion of victims, they may be more likely to suffer specific crimes, including property-related crime, distraction burglary, fraud, and cyber-crime (Brown & Gordon, 2019; Laycock, 2020). Until 2017, the CSEW also excluded adults aged over 59 from the sexual violence and stalking sections of the survey (ONS, 2017). The lack of accurate, long-term data appears to have perpetuated a myth that these crimes do not affect older people (Bows, 2020).

Other researchers consider fear of crime in older people to be 'the bigger problem' than actual crime (Evans & Fletcher, 2000). Much attention has been put towards the 'Victim's Paradox': the perception that older people suffer lower rates of crime but higher fear of crime than younger people (Hale, 1996; Lee et al., 2022; Noble & Jardin, 2020). However, the data supporting this are equivocal (Lee et al., 2022), and it disregards that there are large numbers of older victims (ONS, 2023c). It also implies that older adults are irrational for fearing crime, yet the impact may be greater than in younger victims because of concurrent life events such as declining health, social networks, and reduced income in retirement (Jackson, 2009).

Even studies in older victims have overlooked community crime. Substantial research exists on elder abuse and domestic violence (e.g., Ballentine, 2023; Knight & Hester, 2016; Yunus et al., 2019). However, these are not the only crimes that affect older people: A UN report found that the majority of crimes in older people are related to property, including theft, criminal damage, fraud, and scams (Kratcoski & Edelbacher,

2021). Property-crime can also lead to violent victimisation in older adults – for example, attempting to subdue an assailant breaking into their property ('aggravated burglary'; Kratcoski & Edelbacher, 2021). As the impact of these crimes may be different from elder abuse or domestic violence (Langton & Truman, 2014), separate research is needed.

3.2.2 Crimes Rates in Older Victims

Although accurate data is lacking, crimes against older people are certainly not rare (Bows, 2018). Figures provided by the MPS (Table 1) for the twelve London boroughs in the VIP Trial shows that 9,953 community-crimes were reported between 1st August 2022 to 31st July 2023 by older victims aged 65 and over (MPS Personal Communication, August 2023). Extrapolating this to all 32 London boroughs suggests that an estimated 26,541 crimes were reported by older people in the past year in London alone. Theft and burglary appear to be especially common. Caution is required as some older victims may have reported multiples crimes, and domestic violence was only removed if labelled as such during reporting. Data protection also prevented inclusion of sexual crimes and fraud is likely to be unrepresented as most cases are managed by Action Fraud. Nonetheless, it suggests that large numbers of community crimes are reported by older victims. As 60-70% of crimes go unreported (Buil-Gil et al., 2021; MacDonald, 2002), the true rate of community crime in older victims is likely to be even higher.

Table 1: Data Provided by the MPS for the VIP Trial on Crimes Reported by Older Victims Aged 65 or over across 12 London Boroughs between 31st July 2022 – 1st August 2023 and Estimated Figure if Extrapolated to all 32 London Boroughs.

	Robbery	**Theft from car**	**Theft of car**	**Theft from Person**	**Theft – other**	**Bicycle theft**	**Actual Bodily Harm**	**Grievous Bodily Harm**	**Common assault**	**Criminal damage – property**	**Criminal damage – car**	**Burglary**	**Harassment**	**Fraud and Courier crime****	**Arson**	**Dangerous dog offences**	**Public order offences**
VIP Trial Boroughs* (9,953)	207	1738	814	995	2225	117	392	209	766	266	213	1033	394	228	20	40	296
Estimate Figure for all 32 London Boroughs (26,541)	552	4635	2171	2653	5933	312	1045	557	2043	709	568	2755	1051	608	53	107	789

*VIP Trial boroughs = Camden, Islington, Barnet, Enfield, Hackney, Haringey, Tower Hamlets, Newham, Havering, Redbridge, Waltham Forest, Barking & Dagenham.
** Fraud is likely to be underestimated as there is a separate reporting stream for fraud (Acton Fraud) not included here.
For definitions of crime types, see: MPS (2023a).

3.3 Why Might Community Crime in Older Victims Occur?

Criminal victimisation is said to occur when 'suitable targets' and 'motivated offenders' converge in time, space, and in the absence of someone or something that can prevent it (Routine Activity Theory; Cohen & Felson, 1979).

Studies have largely discussed this convergence happening online, as cybercrime is becoming increasingly problematic as more older adults use the internet (Burton et al., 2022; Tripathi et al., 2019). Although the degree of risk is debated (Burnes et al., 2017; Havers et al., 2023; Kemp & Erades Perez, 2023), multiple vulnerability factors associated with late adulthood have been reported. For example, declining memory and cognitive impairment may reduce the ability to evaluate information and detect deception (Shao et al., 2019). Scammers may target older people because they are perceived as being overly trusting (Shao et al., 2019), relatively wealthy, and lacking cybersecurity skills (Tripathi et al., 2019). Socially isolated older adults have less people around them to intervene (Shao et al., 2019) and may be more likely to engage with perpetrators in an attempt to foster social connections (Lachs & Han, 2015). Studies have also reported that older adults who perceive their time as depleting have increased attentional bias towards reward-based information over risk-based information (Shao et al., 2019).

A recent review of cybercrime studies proposed seven key risk factors in older people: 1) poor cybersecurity skills or awareness 2) poor health 3) memory loss 4) social isolation 5) relative wealth 6) societal values perpetuating shame, fear or loss of independence and 7) targeted scam content (Burton et al., 2022). A subsequent study analysing CSEW data supported poor health and memory loss as a risk factor in older adults but was unable to examine the other vulnerabilities in-depth, supporting the need to strengthen data on this (Havers et al., 2023).

Explanations for victimisation more broadly have predominantly focused on younger people (Goergen & Beaulieu, 2010). The risk is considered to be increased by spending more time in public places, especially at night or with strangers (Lifestyle Exposure Theory; Hindelang et al., 1978). Daily activities, such as going to work or socialising, also leave homes vacated (Cohen & Felson, 1979). Older adults are therefore considered less at risk based on spending more time at home (Bows, 2019a). However, this may be an ageist assumption as many older people lead active lifestyles (Levy et al., 2022). Engagement in illicit activity is another risk factor for victimisation associated with young people (Smith & Ecob, 2007), but the numbers of older offenders are increasing with population ageing as well as older victims (Holzer et al., 2022; Kratcoski & Edelbacher, 2021). It should therefore not be assumed that older people are immune to the risk factors that affect younger people.

There may, however, be specific factors that make some older adults more vulnerable than others. For example, older adults from ethnic minorities are more likely to be victims than white older adults (Gov.uk, 2021b). People who have been victimised previously are more likely to be subsequently victimised (Ruback et al., 2014). Consistent with cybercrime studies, people with disabilities, poor health, or frailty are at greater risk of violent theft (Commissioner for Older People for Northern Ireland; COPNI, 2023; Rossetti et al., 2016). There may also be overlap with risk factors for elder abuse as crimes such as distraction burglary[1] involve perpetrators pretending to be people in positions of trust including relatives, tradesmen, public services workers, or charity collectors (Goergen & Beaulieu, 2010).

[1]Citizen's Advice (2019) describe distraction burglary as person(s) trying to gain access into another person's home through deception with the intention of committing theft. It is often conducted in pairs, with one distracting while the other person steals. An example of a common tactic is pretending to be from a utility company stating there is a problem in the local area. https://www.citizensadvice.org.uk/Global/CitizensAdvice/MMcGinnconsumered/doorstep/what%20is%20distraction%20burglary.pdf

Poor mental health has been associated with victimisation, but most studies are cross-sectional, so it is unclear whether this is a risk factor or a consequence (e.g., Meijwaard et al., 2015). A two-wave longitudinal study found psychological symptoms were prospectively associated with subsequent victimisation (OR: 1.88; 95% CI: 1.25-2.83) (Bhavsar et al., 2019). However, this was not found in adults over 55 and the study spanned just six years, so the possibility of victimisation before then cannot be eliminated. A recent longitudinal study of twins discordant for victimisation found evidence in both directions, which was complicated by genetic and environmental factors (Gonggrijp et al., 2023). As there is unlikely to be a simple causal relationship, life-course research to clarify pathways is recommended (Gonggrijp et al., 2023).

More research on the drivers of community crime in older victims is needed to perform prevention initiatives (Kratcoski & Edelbacher, 2021). However, understanding the impact of crime in older victims is a necessary starting point to supporting this population (M. J. Gray & R. Acierno, 2002).

3.4 Impact of Community Crime in Older Victims

My thesis studied psychological impact in-depth, however, crime can also have financial, physical, and social consequences in older victims (Brown & Gordon, 2019; Green & Roberts, 2008).

3.4.1 Financial Impact

The financial impact of crime may be especially damaging for older people because they have less opportunity to recoup financial losses than younger people (Rabiner et al., 2004). Crimes such as theft, burglary, and criminal damage all incur costs of replacement, repairs, or insurance claims (Green & Roberts, 2008). In countries with private

healthcare, violent crime can result in expensive medical bills (Green & Roberts, 2008). Fraud by definition is financially impactful (Metropolitan Police Service, 2023). In May 2022 to 2023, adults aged over 70 lost an estimated £12.6 million to courier fraud alone (City of London Police, 2023b). Older victims are often reluctant to report fraud, which may increase their risk of repeat victimisation and further losses (Pak & Shadel, 2011).

3.4.2 Physical Impact

Older victims of violence are more likely to need medical care and are at greater risk of immediate death than younger people (Bachman et al., 2004; Chu & Kraus, 2004). There may also be long-term physical complications from a range of crime types in older victims. For example, burglary, fraud, and violence have all been associated with accelerated mortality (Burnett et al., 2016; Donaldson, 2003; Dong et al., 2013). Depression attributed to victimisation in transgender older adults was found to have an even bigger health impact than smoking or obesity (Fredriksen-Goldsen et al., 2014).

3.4.3 Social Impact

Older victims are less likely to obtain procedural justice than younger people, such as the offender being caught or sentenced (Brown & Gordon, 2022; HMICFRS, 2019). Criminal justice agencies often fail to provide appropriate assistance, and older victims are often reluctant to ask for it (Brown & Gordon, 2022). Older victims of fraud are also often 'victim-blamed' and assumed to be greedy and gullible, a perception also commonly held by older victims themselves (Cross, 2015).

A large (N = 2,321) ten-year cohort study found that older victims of violence were over twice as likely to be placed in a nursing home than older non-victims, even after controlling for predictors such as cognitive impairment (Lachs et al., 2006). Only small

numbers in the sample had been injured, suggesting it may instead have been due to stress or family members encouraging older victims towards 'safer' environments.

3.4.5 Psychological Impact

Initial government reports suggest that psychological impact in older victims may include flashbacks, trauma, shock, anger, shame, embarrassment, heightened fear, and awareness of vulnerability (Commissioner for Older People for Northern Ireland; COPNI, 2023; HMICFRS, 2019). However, these reports often did not specify whether this was community crime or family/carer crime. Depression, anxiety and PTSD have also been reported in older victims of violence, but this study also did not distinguish between crime types, and as a treatment-seeking sample, may reflect the more severe end of psychological impact (Gray & Acierno, 2002). Improved evidence on the psychological impact in older victims of community crime is therefore needed.

3.5 Interventions

Given the impact of crime, research has largely focused on preventing it (Gearhart, 2022). Crime prevention interventions broadly include offender rehabilitation, legislation, police intervention (e.g., stop-and-search), situational prevention (e.g., CCTV), and improvements to community cohesion (Weisburd et al., 2017). Initiatives to prevent crimes against older adults include psychotherapy and coaching for carers, which have been found to reduce incidents of elder abuse (Gassoumis et al., 2023; Khanlary et al., 2016; Livingston et al., 2013), and financial literacy programmes, which have been found to reduce scam susceptibility (Sur et al., 2023).

Support for victims after a crime has been comparatively understudied (Gordon & Brown, 2023; Youstin & Siddique, 2019). Given the large numbers of crimes that occur

every year despite prevention efforts (ONS, 2023a), it is essential that evidence-based care is also available (The Association of Police and Crime Commissioners, 2022). Although assistance in the UK is available through Victim Support, an independent charity offering counselling and practical advice (Victim Support, 2023), only small proportions of victims use such services (McCart et al., 2010; Youstin & Siddique, 2019). They are also not intended to replace psychological therapies, which Victim Support has actively campaigned for (Parliament, 2023).

The evidence-base for psychological therapies for crime victims is limited (Lumer et al., In prep), however. Studies have mostly focused on victims of sexual assault, and have been restricted by small sample sizes and short follow-up periods (Lumer et al., In prep). Prolonged exposure[2] and eye-movement desensitisation and reprocessing[3] (EDMR) have been found to improve PTSD symptoms (Foa et al., 1991; Rothbaum, 1997). Testing of CBT for sexual assault victims is also underway, but the results have not yet been published (Hahn et al., 2023). Self-guided CBT was found to produce sustained improvement on adjustment disorder measures in burglary victims (N = 54), but the effect sizes were small-to-medium, and only participants who had responded to adverts were included (Bachem & Maercker, 2016). Further testing of different interventions for victims of a range of crime types and psychological disorders is therefore needed.

The limited studies in older victims have largely focused on elder abuse. For example, a nine week therapeutic intervention involving psychoeducation and strategies to manage interactions with an abuser was found to be promising for treating depression

[2] Prolonged exposure is a type of CBT for PTSD that encourages patients to gradually approach trauma-related situations, feelings, and memories they may have been avoiding (The National Centre for PTSD, 2023)

[3] EDMR is a structured therapy that encourages patients to focus on a trauma memory alongside bilateral stimulation (eye-movements), which has been found to reduce the intensity of memories, helping the individual to process it (APAb, 2017).

(Sirey et al., 2021). However, the different nature of these crimes suggests that interventions for victims of elder abuse may not be relevant to older victims of community crime. Improved evidence on interventions for this population is therefore also needed.

3.6 End of Section Summary

Older victims of community crime have been under-researched compared to elder abuse, domestic violence, and younger victims. Knowledge on psychological impact and support for this population is therefore lacking. I embedded my thesis within the VIP Trial and aimed to strengthen evidence in this area by conducting a systematic review of existing research, a qualitative study on coping, and a mixed-methods study on safety-seeking behaviours.

Part II: Study I

A Systematic Narrative Review and Quality Appraisal of Studies on Psychological Impact and Interventions in Older Crime Victims

Chapter 4: Systematic Review Methods

I conducted a systematic review to establish what is already known about psychological impact and interventions in older crime victims. The purpose was to appraise the strengths and limitations of the existing research and identify gaps in the evidence that my subsequent studies could target. My systematic review was guided by good practice guidelines from Cochrane, the Reviews for the Centre of Dissemination, and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance (PRISMA checklist; Appendix 6.1).

4.1 Review Questions

I aimed to address the following questions: Q1) What is the psychological impact of crime on older victims? Q2) What interventions are there for psychological impact in older victims? Q3) What are the strengths and weaknesses of the existing literature and how can the evidence base be improved?

4.2 Protocol

My review protocol was registered on Prospero on 14th August 2019 (CRD: 42019140137). Protocol amendments were submitted on 28th February 2022 and 12th May 2022.

4.3 Inclusion and Exclusion Criteria

I included peer-reviewed studies of any design published in English from 1980 to November 2023 that presented data on psychological impact or interventions for older victims of community-crime aged 50 and over. Psychological impact was defined as any

emotional or behavioural response (Ridner, 2004), and could be recorded objectively or subjectively. Interventions could be any format and include any comparator, including treatment-as-usual and no care. As there is no agreed definition of 'older adults', I selected a conservate definition of 50 and over, as this was the lowest age identified in a review of ageing definitions, and it is recommended that reviews be over-inclusive to capture all relevant literature (Cosco et al., 2014; Higgins et al., 2023).

I excluded studies on crimes perpetrated by friends, family, or carers, unless analysed and reported separately. Studies on dementia, serious mental illness, personality disorder, or intellectual disability were excluded as the focus was on psychological impact rather than pre-existing conditions. Studies on alcohol or substance misuse were excluded as these may be considered a consequence of distress rather than a direct outcome. I excluded grey literature studies as recommended for reviews with limited resources as it can introduce further bias rather than reduce it (Egger et al., 2003).

4.4 Search Strategy

My search strategy was developed through consultation with a librarian (Appendix 6.2). I searched PsycINFO, MEDLINE, Embase, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PTSDPubs to search existing literature published between 1980 to August 2019. I conducted updated searches in August 2021, April 2022, and October 2023. A broad date range of over four decades was chosen to identify as much relevant literature as possible. The key words were older adult' AND 'mental health' AND 'crime victim'. Synonyms of these words – including the American terms for crime 'felony' and 'misdemeanour' – were combined using truncation and Boolean functions.

> *'older adult*' OR 'older people' OR 'older victim*' OR 'older complainant' OR aged OR elderly OR pensioner* OR 'senior citizen*' AND crime* OR felon* OR misdemeanour* OR assault OR theft OR fraud OR robbery OR burglary OR violen* OR 'interpersonal*

violen' OR rape OR scam* OR arson OR 'criminal damage' OR 'distraction burglary' OR stalking OR harassment OR phishing OR cybercrime OR cyber-crime OR 'cyber crime' AND wellbeing OR anx* OR depress* or traum* OR distress OR 'psychological impact' OR 'mental health outcome*' OR 'psychiatric outcome*' OR 'psychological outcome*' OR 'psychological symptom*' OR 'psychiatric symptom*'*

Search results were uploaded into EndNote and duplicate records were removed. Screening was conducted using the web application Rayyan QCRI (Ouzzani et al., 2016) to mark whether each result was eligible and to assess reviewer consensus. A second reviewer and I independently screened titles and abstracts of search results and assessed the full-text of potentially relevant papers before conferring to assess agreement (99.8% agreement, k= 0.66, 95% CI: 0.52-0.79, ('substantial agreement'; Cohen, 1988). A third reviewer was nominated to make final decisions on papers where eligibility remained unclear even after discussion (Appendix 6.3). I also screened the reference lists of all eligible papers for further studies. I also searched The Cochrane Central Register of Controlled Trials (CENTRAL) and International Standard Randomised Controlled Trial Number (ISRCTN) registry.

4.5 Data Extraction and Quality Appraisal

I extracted the following data into pre-populated tables: study design, setting, sample size, sample characteristics, crimes included, mental health outcomes, recruitment procedures, duration between crime occurring and assessment, analytical strategy, lengths, and procedures. Additional data extraction for intervention studies included treatment and comparator characteristics. Missing data was recorded as 'not reported'. A second reviewer crosschecked 20% of the data extraction and found no errors. I quality appraised studies using the Mixed Methods Appraisal Tool (MMAT) version 18 (Hong et al., 2018) as recommended for reviews including different study designs (Appendix 6.4).

I did not exclude studies of low methodological quality as I aimed to quality appraise the existing literature.

4.6 Synthesis

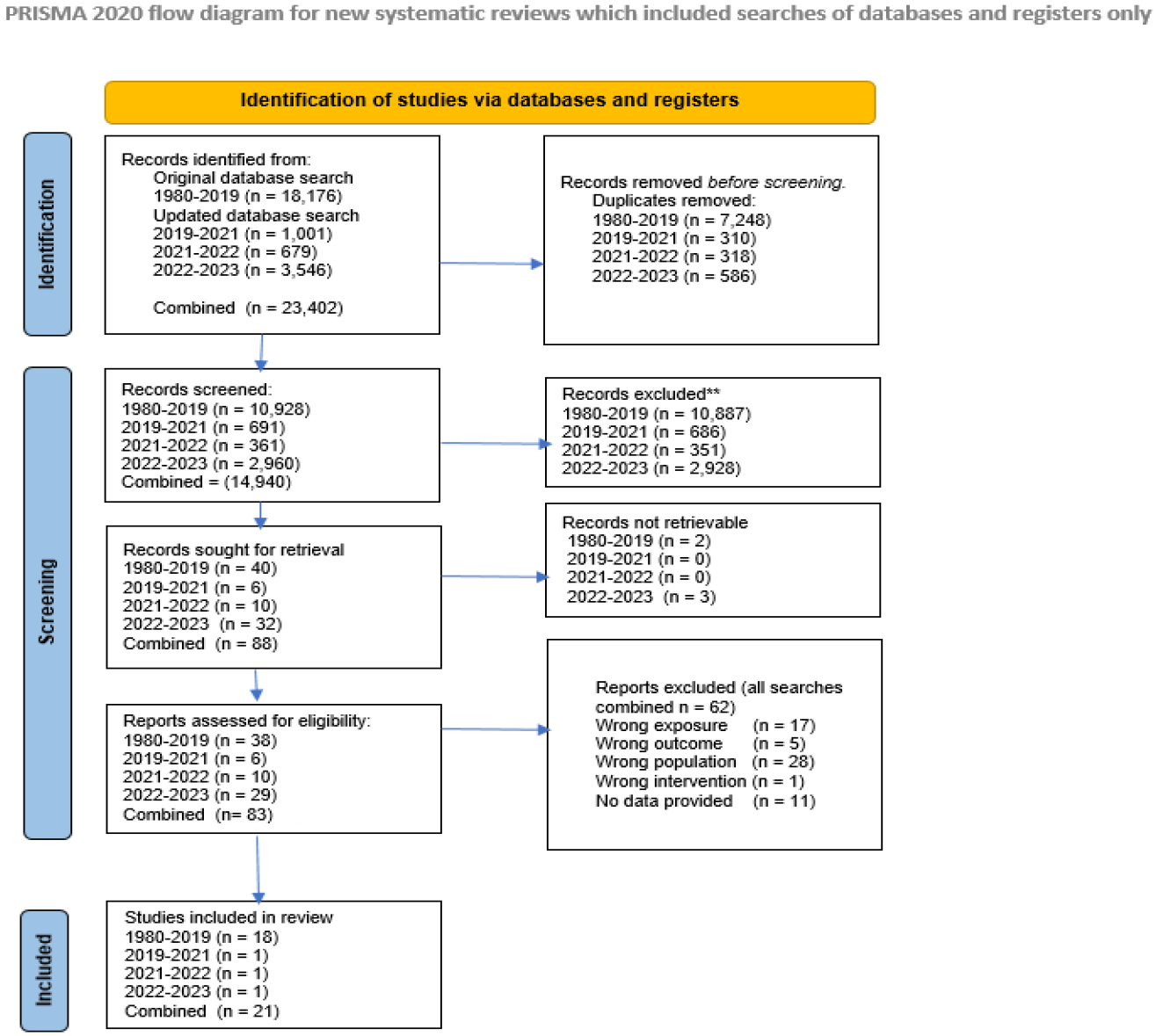
I summarised the results using narrative synthesis as recommended for systematic reviews that include non-RCT studies (Popay et al., 2006). Narrative synthesis aims to summarise and explain evidence, compare and contrast studies, explore relationships within the data, and appraise research quality to produce a summary of knowledge (Lisy & Porritt, 2016; Popay et al., 2006). I considered meta-analysis, but this was unsuitable as eligible studies were heterogenous in aims, methods, and sample characteristics.

Chapter 5: Systematic Review Screening Results

The searches combined produced 23,402 results which, once duplicates were removed, left 14,940 results, which a second reviewer and I screened. Most (n = 14,852) were excluded based on titles and abstracts, but full-text reviews were completed for 83 (Appendix 6.3). Of these, 62 were excluded because: A) the crime was committed by a perpetrator in a close relationship with the victim, B) the study was on younger victims, C) the study was a review or protocol paper that did not present data, D) the outcome was not psychological, or E) the intervention was not for psychological impact. One intervention study (Acierno et al., 2004a) included older victims of domestic violence but clearly reported that this was the minority of the sample and that no differences were found compared to other crime groups in any analyses. I decided to include this study and submitted a protocol amendment explaining this decision to Prospero.

This resulted in 21 papers for inclusion in my review. Figure 4 illustrates the full selection process using the PRISMA 2020 flow diagram (Page et al., 2021).

Figure 4: PRISMA 2020 Flow Diagram of Searches for My Systematic Review



5.1 Included Studies

Of the 21 studies, four included intervention research. The 21 studies were published between 1985 and 2023 and were: cross-sectional (n = 9), case studies (n = 2), qualitative (n = 4), randomised controlled trial (n = 2), descriptive intervention (n = 1), prospective longitudinal (n= 1) and secondary analysis (n = 2). Most (n= 18) were from Western countries, except for two in India and one in China (Qin & Yan, 2018; Muhammad et al., 2021; Tripathi et al., 2019). The mean sample ages ranged from 60 to 79. The crimes

included across the studies were burglary, vandalism, robbery, mugging, physical assault, sexual assault, rape, distraction burglary, transphobic hate crime, racial hate crime, fraud, cybercrime, and other scams. The characteristics of included studies are summarised in Table 2.

5.2 Quality Appraisal

I quality appraised the 21 studies using the MMAT (Hong et al., 2018), an overview of which is presented in Appendix 6.4. I did not exclude studies of low methodological quality as I aimed to appraise the strength and limitation of the overall evidence.

Observations across the literature included: 1) many studies lacked detail on methods, 2) it was often unclear which crimes were included in studies, 3) reporting of sample characteristics, including mean age, gender and ethnicity, was inconsistent, 4) of the studies that did report ethnicity, samples were predominantly white, 5) studies varied on how long after the crime the outcome was measured; in some cases, the crime may have occurred much earlier in life, 6) different definitions of psychological impact made comparisons across studies challenging, 7) six studies included older victims alongside other populations or traumas, meaning examination of psychological impact in older crime victims was brief, 8) there was little consideration of how differences in frailty, physical health, and global functioning may influence outcomes, 9) community crimes were often not clearly distinguished from carer/family crimes, 10) no studies obtained data on pre-crime psychological health, limiting inferences around causality and direction thereof, 11) studies often did not declare whether ethical approval was obtained or outline ethical considerations in their research, 12) only feasibility intervention data has been published, and 13) the challenges of timely identification and recruitment of older victims meant that many studies used sampling methods such as

convenience or random selection, which often had low response rates, risking bias and limiting generalisation. Intervention studies aimed to address this by collaborating with the police or healthcare agencies, but these samples were still limited to those known to those services.

5.3 Narrative Synthesis

I divided my synthesis into findings on psychological impact (Chapter 6) and psychological interventions (Chapter 7), with psychological impact findings further organised by study aims. Summary characteristics of all included studies are presented in Table 2. Psychological impact results are summarised in Table 3 and psychological interventions results are summarised in Table 4.

Table 2: Summary Characteristics of Studies Included in my Systematic Review

	First Author (year)	Place	Study Design	Sample Size (N)	Mean Age	% Female	% Caucasian	Crimes Under Study	Mental Health Outcomes Studied
1	Krause (1986)	USA	Cross-sectional	332	73.4	66%	64%	Crime and legal matters (e.g., robberies, assault, vandalism)	Depressive symptoms
2	Jones (1987)	UK	Case studies	12	Not reported	Not reported	Not reported	Nuisance, vandalism, burglary, fraudulent entry, theft	Describes older victims as 'upset', 'distressed',
3	O'Neill (1989)	Ireland	Cross-sectional	272	74	Not reported	Not reported	Burglary	Anxiety, depression, sleep disorder, fear of going out, fear of further crime
4	Norris (1992)	USA	Cross-sectional	Not reported	Not reported	Not reported	Not reported	Robbery, physical assault, sexual assault	PTSD, perceived stress
5	Tyra (1996)	USA	Case study	1	64	100%	Not reported	Rape	Rape trauma syndrome
6	Simpson (1996)	UK	Cross-sectional	350 + 5 case studies	Not reported	Not reported	Not reported	Actual or attempted burglary, robbery, assault, or deceit	PTSD
7	Spalek (1999)	UK	Qualitative	25	67	Not reported	Not reported	Pension fraud	Subjectively described anger, anxiety, self-blame,
8	Acierno 2004)	USA	RCT	6	66.9	66.5%	53%	Violence	Anxiety, depression
9	McGraw (2004)	UK	Descriptive intervention	77	79	Not reported	Not reported	Distraction burglary	Depression, anxiety
10	Brunet (2013)	France	Prospective Longitudinal	39	72.4	64.1%	Not reported	Physical assault	PTSD
11	Fredriksen-Goldsen (2014)	USA	Cross-sectional	174	60.97	Transgender sample, no further	79.1%	Transgender victimisation (including physical, verbal, or sexual threat or assault,	Depressive symptomatology, perceived stress

						details provided		threat of being outed, property damage)	
12	Cross (2015)	Australia	Qualitative	85	Not reported (Range 50-83)	45.9%	Not reported	Fraud, attempted fraud	Self-blame, shame, embarrassment
13	Iganksi (2015)	UK	Secondary analysis	Not reported for older adults	Not reported for older adults	Not reported for older adults	Not reported for older adults	Racially-motivated hate crime	Internalised emotions (anxiety, panic attacks, crying, tears, depression, difficulty sleeping, fear, loss of confidence, feeling vulnerability, shock) and externalised emotions (anger, annoyance)
14	Tan (2016)	UK	Cross-sectional	280*	Not reported	Not reported	Not reported	Violent crimes (threatening / abusive behaviour, violent assault, robbery / mugging) and non-violent crimes (burglary, break-in, vehicle-related theft, theft of credit card, other forms of theft, vandalism / property damage)	Stress, sleeping difficulties, lack of confidence, depression, panic attacks
15	Serfaty (2016)	UK	Longitudinal + pilot RCT	581 (26 RCT)	71.7	55.2%	86.1%	Burglary, pickpocket, fraud, criminal damage, assault, harassment, theft	Depression, anxiety, PTSD

16	Reisig (2017)	USA	Cross-sectional	2000	72.42	63.7%	90.4%	Theft, fraud, violence	Depressive symptoms
17	Qin (2018)	China	Cross-sectional	453	72.29	56.3%	0%	Theft, fraud, burglary, snatch theft, robbery, attack, sexual assault	Mental health (not otherwise specified)
18	Tripathi (2019)	India	Qualitative	6	Not reported	0%	0%	Cyber-crime	Qualitative impact
19	Bailey (2020)	UK	Qualitative	80	Not reported	71%	Not reported	Scams	Qualitative impact
20	Muhammed (2021)	India	Cross-sectional	402	Not reported for sub-sample	Not reported for victim sub-sample	Not reported but conducted in India	Violent crime (assault, mugging, threat to life or others)	Major depression
21	Kemp (2023)	EU-wide	Secondary analysis	26,735 of which 13,313 were aged over 50	Not reported	Not reported	Not reported	Consumer fraud	Anger, irritation, embarrassment, stress

Chapter 6: Narrative Synthesis of Studies on the Psychological Impact of Crime in Older Victims

6.1 Overview of Psychological Impact

Through synthesising all 21 studies, I identified a total of 31 psychological impacts. These were: feeling upset, frightened, disbelief, crying, embarrassment, fatigue, poor sleep, intrusive thoughts, feeling vulnerable, insecurity, anger, annoyance, irritated, post-traumatic stress disorder, fear of further crime, fear of going out / agoraphobia, fear of staying alone, impaired concentration, anxiety, depression, reduced self-esteem, loss of trust/ mistrust, loss of confidence, shame, scepticism, flashbacks, stress, panic attacks, self-blame, shock, and behaviour changes. The behaviour changes I identified included avoidance of social activities, carrying as little money as possible, locking doors and windows, avoidance of online banking, and monitoring belongings in crowded places.

6.2 Psychological Impact Studies

6.2.1 Case studies

Two early studies from the UK and USA provided case study data (Jones, 1987; Tyra, 1996). The UK study summarised twelve crime-related incident reports from wardens of sheltered accommodation, which described older victims of burglary and vandalism as 'upset' and 'frightened' (Jones, 1987). Fraudulent entry and theft was reported to 'affect them profoundly', and it was suggested this may be because of their emotional attachment to their home (Jones, 1987, pg 195-96). The USA study described acute and chronic experiences of 'rape trauma syndrome' in an older rape victim (Tyra, 1996). Acute experiences included disbelief, recurrent crying, embarrassment, fatigue, poor

sleep, intrusive thoughts, feeling vulnerable, insecurity, and intense anger. Chronic experiences included fear of going out at night or staying alone, poor concentration, intrusive thoughts, and ongoing anger. Together, these studies provide insight into the nature of psychological impact in older victims but cannot be generalised due to insufficient numbers.

6.2.2 Qualitative Studies

Four qualitative studies were identified, all focusing on fraud, indicating an evidence gap for qualitative research in older victims of other crimes. These included older victims of the Robert Maxwell Pension scandal in the UK (Spalek, 1999), attempted and completed scams in Australia and the UK (Bailey et al., 2020; Cross, 2015), and cyber-scams in India (Tripathi et al., 2019). Reported themes on psychological impact in these studies included: anxiety, depression, reduced self-esteem, loss of trust and confidence, embarrassment, shame, increased scepticism, mistrust, and behaviour changes (e.g., avoiding online banking). Self-blame was observed in older victims who felt personally responsible but was absent in older victims scammed by a trusted pension provider; anger was noted instead (Spalek, 1999). Humour was found to be a coping mechanism for some older victims, but this appeared to trivialise their experience, normalise victim-blaming, and prevent disclosure (Cross, 2015).

It is a strength that two of the studies considered both attempted and completed scams, but contradictory findings were observed: one observed psychological distress in victims who suffered severe financial losses only (Cross, 2015), the other reported that malicious intention was more distressing (Bailey et al., 2020). Notable across all four studies was limited detail on interviewing approach (e.g., one-to-one, focus groups), topic guide (e.g., semi-structured), analytical approach, theoretical assumptions, and

reflections on researcher background and possible personal biases. All four appeared to approach the data deductively, seeking evidence to support existing ideas on psychological impact, but they did not inductively explore whether there were other impacts that had not yet been considered. Taken together, these studies support that fraud adversely affects older victims but inductive analysis with older victims of different crime types is needed to understand the full range of impact.

6.2.3 Descriptive Surveys

Three studies conducted surveys in larger samples of older people asking whether they had been a victim previously and, if so, what psychological impact they had experienced. The first was in older hospital inpatients in Ireland (N = 272) (O'Neill et al., 1989), which found that of those who reported having been burgled in the previous two years (n =72, 26%), almost all (90%) reported a psychological impact. These included fear of further crime (n = 57, 79%), anxiety or depression (n= 36, 50%), sleep disturbance (n=32, 44%) and agoraphobia (n=32, 44%). The second study was in older adults accessing a community mental health clinic in Manchester, UK (N= 350) (S Simpson et al., 1996). This study found that 100 participants reported having been crime victims; of whom, five (5%) met diagnostic criteria for PTSD. It was not reported when the crimes occurred nor what the clinical presentation of the 95 victims who did not meet diagnostic criteria for PTSD was like, limiting comparisons between these two studies. These two surveys were also conducted in convenience samples of older people accessing healthcare services so they cannot be generalised to all older victims.

The third study tried multi-stage sampling 800 older people living in urban China, however, the response rate was low (n= 453, 57%)(Qin & Yan, 2018). Over half of the respondents had experienced one or more types of crime (n =254, 56%). Theft (n = 198,

44%), fraud (n= 140, 31%) and burglary (n = 253, 56%) were the most frequently reported whilst physical assault (n = 5, 1%) and rape (n = 1, 0.2%) were the least reported. Experience of crime was a consistently significant predictor of poor mental health on the General Health Questionnaire (Pan & Goldberg, 1990), even when physical health and sociodemographic characteristics were controlled for.

Taken together, these three studies suggest that being a victim of crime is associated with high levels of distress, although they cannot be generalised to all older victims. As psychological health before the crime was not known, it is unclear whether poor mental health was because of the crime or pre-existing.

6.2.4 Psychological Impact in Older Victims Compared to Older Non-Victims

One recent study of depression using data from a large national survey on ageing in India (N = 31,646) found that 1.32% of respondents (n= 402) reported having been victims of violent crime in the previous 12 months, such as assault or mugging (Muhammad et al., 2021a). Using the Short-Form Composite International Diagnostic Interview for major depression, 17.7% scored positive compared to 8.52% of non-victims (UOR: 1.54, CI: 1.05-2.26). After controlling for sociodemographic and health variables, the adjusted odds ratio increased to 1.84 (CI: 1.15-2.95). A strength of this study is that it was in a representative sample of older victims in India, and it sought to measure the association between crime and depression within a defined time-period. However, the direction of association remains unclear, and findings may not be generalisable to non-violent crime.

6.2.5 Psychological Impact of Crime Compared to Other Trauma Types in Older Victims

One study compared psychological outcomes after a crime with another trauma-type in older victims (Brunet et al., 2013). Older adults seeking emergency medical treatment

for either physical assault or motor vehicle accidents were assessed for peritraumatic distress symptoms, and followed up 1 week and 1, 6 and 12-months post-incident. Older victims of physical assault were found to score significantly higher across time-points on the Clinician Administered PTSD Scale (CASP; Weathers et al., 2013) (mean = 36.1, 95% CI; 22.8-49.3) than older victims of motor vehicle accidents (mean = 15.2 95% CI; 10.8-19.7) ($t = 2.23$; $p = .03$). Consistent with the ageing survey in India, this demonstrates the severity of psychological impact in older victims of violence. By using the gold-standard assessment tool for PTSD (CASP) and partnering with a local hospital, assessment was at clearly defined time-points. However, research to understand the severity of psychological impact in older victims of less violent crimes is also needed.

6.2.6 Older Victims Compared to Younger Victims

Four studies investigated psychological impact across age groups. One found no difference between younger and older victims (Tan & Haining, 2016), two found older victims were less affected than younger victims (Iganski & Lagou, 2015; Norris, 1992b), and one found older victims were more affected than younger victims (Kemp & Erades Perez, 2023). These retrospective studies had long recall periods, meaning acute distress was not measured and responses may have been affected by recall biases.

The results may also have been conflated. For example, one study (Tan & Haining, 2016) found that female victims were more likely to report psychological symptoms than male victims, but did not provide a gender breakdown within age groups. The lower distress scores in older males may therefore have masked the higher distress scores in older females. Another study found that psychological impact was lower in older victims who considered themselves financially secure (Kemp & Erades Perez, 2023), suggesting individual differences within these groups may be more relevant than age. Researchers

should consider whether there is clinical value in investigating whether one age group is more affected than another as erroneous conclusions in either direction risks excluding vulnerable populations from research.

6.2.7 Individual Differences on Adverse Psychological Outcomes in Older Victims

Studies often analysed older victims as a homogenous group, however, some have begun to consider the factors which may contribute to distress within this population.

6.2.7.1 Type of Crime

Psychological distress was reported in older victims of assault (Acierno et al., 2004a; Brunet et al., 2013), rape (Tyra, 1996), fraud (Bailey et al., 2020; Cross, 2015; Spalek, 1999; Tripathi et al., 2019), burglary (Jones, 1987), distraction burglary (McGraw & Drennan, 2006), mugging (Muhammad et al., 2021a), and vandalism (Jones, 1987), but less has been reported on the impact of low-value high-frequency crimes such as petty theft. It therefore remains unclear whether psychological distress arises from all crime or specific crime types. Equivocal findings in the fraud studies (Bailey et al., 2020; Cross, 2015) also raise the question whether it is the crime itself or the malicious intent that is distressing in older victims.

6.2.7.2 Sociodemographic Characteristics

Comparatively few studies considered sociodemographic characteristics on psychological outcomes. The exceptions were the surveys of older people in urban China (Qin & Yan, 2018) and across India (Muhammad et al., 2021a), which both found a strong association between experiencing a crime and mental health even after variables such as health, gender, age, education, household finances, and living arrangements were controlled for. Of the victims of violent crime in India, older females living in rural areas

had the highest odds of suffering major depression (AOR:2.27, CI:1.25-4.14) (Muhammad et al., 2021a). Further research is needed on sociodemographic and health variables on psychological outcomes across a range of crime types.

Two other studies highlighted that crimes targeted towards marginalised groups (called 'hate crime' in the UK and 'bias crime' in the USA) may be particularly distressing. A study in the USA (Fredriksen-Goldsen et al., 2014) found that transgender older adults (n= 174) reported higher lifetime victimisation and depressive symptoms than lesbian, gay and bisexual (n= 2,201) older adults. Victimisation and stigma explained the highest proportion of the total effect of gender identity on health outcomes in transgender older adults, even when compared to other health-related behaviours including smoking and obesity. Another study examining data from the Crime Survey for England and Wales found older victims of racially motivated hate crime were at increased risk of self-reported internalised emotions, although standardised outcomes measures were not used, and the findings were not statistically significant (Iganski & Lagou, 2015).

6.2.7.3 Social Support

Two studies suggest that social support may be helpful for coping in older victims. An early study (N= 332) found that depressive symptoms were lower in older crime victims with high emotional support than those with low emotional support, although this was not statistically significant (Krause, 1986). However, these findings were supported by a more recent study (N= 2,000) which found that although older victims reported increased depressive symptoms after the crime, the link was significantly weaker in those with strong attachments to their spouse or adult children (Reisig et al., 2017). It is therefore noteworthy that one of the qualitative fraud studies (Cross, 2015) found that

shame may be a barrier to disclosure in older victims, as this may limit opportunities for social support.

6.2.7.4 Changes in Behaviour

Several studies reported behaviour changes in older victims including avoiding online banking, avoiding unidentified callers, and increasing home security (Bailey et al., 2020; Qin & Yan, 2018; Tripathi et al., 2019). Crime victimisation was found to significantly correlate with 'constrained behaviours' in older people in China (Qin & Yan, 2018) and avoidant behaviours in older people in the USA (Reisig et al., 2017). Strong spousal attachments were also found to moderate this link (Reisig et al., 2017). However, whilst these studies tested a relationship between crime and protective behaviours, and crime and mental health, neither tested a relationship between protective behaviours and mental health. Protective behaviours were also measured based on presence or absence (Qin & Yan, 2018) or frequency (Reisig et al., 2017), which may not be valid in older victims as they were not asked whether this was a change since the crime. In the survey in China, nearly all older people (98.5%) reported engaging in protective behaviours yet only 56% reported having been victims, making it unclear whether these behaviours were in response to the crime or pre-existing. The American study (Reisig et al., 2017) also defined avoidance as non-attendance at activities such as the cinema or leisure sports, which may have been confounded by poor mobility or physical health problems. Nonetheless, given several studies observed behaviour changes in older victims, further investigation using valid assessment tools to strengthen understanding of these associations is needed.

Taken together, these studies suggest that crime type, sociodemographic characteristics, social isolation, and behaviour changes are possible factors that may influence how older victims psychologically respond to a crime.

Table 3: Summary Findings of Studies Reporting on Psychological Impact

First author	Setting	Study Aim	Recruitment Procedure	Length Between Crime and Assessment	Time Between Assessment and Follow-up	Crime Assessment	Outcome Measures	Data Analysis	Results	Strengths	Weaknesses
Krause (1986)	Community	To examine whether social support buffers the deleterious effects of crime on depressive symptoms	Random household selection	Events occurring within the previous year	N/A	Stressful Life Events Questionnaire (created for the study)	Centre for Epidemiologic Studies Depression Scale	Ordinary least squares multiple regression	Post-crime depressive symptoms were lower in older victims with high emotional support (b = .689) than those with low emotional support (b = 1.17). Minimal differences were found in post-crime depressive symptoms between older adults with high informational support (b=.641) compared to low informational support (b=.630)(N = 332)	Considers explanatory factors and protective factors; large sample size; asked about recent crimes; standardised measure of depression	Recall bias; crime assessed as an umbrella category including legal disputes
Jones (1987)	Independent living sheltered housing	To describe impact of crime on victims.	Data from complaints to wardens	Not reported	N/A	Complaints to wardens	Not used	Not used	Described older victims of burglary and distraction burglary as distressed and upset. Common feature was that all happened inside their homes	Early attempt to understand impact in older victims and explanatory factors	Cannot be generalised, did not consider crimes outside of housing association, limited to complaint data, no standardised measures

O'Niell (1989)	Hospital in-patients	Comparison of burglary effects between older and younger people	Admissions to hospital	2 years	N/A	Asked if had been a victim of burglary	Not reported	Chi-Square ($\chi 2$)	36% reported anxiety or depression	First of its kind, clinical recommendations made	Small sample, one study site, no standardised measures, not generalisable
Norris (1992)	Community	To determine impact of different trauma events (including crime) on different demographic groups (including older adults)	Investigator toured an urban area for signs of hurricane damage and selected areas with similar demo-graphics	Lifetime and past year	N/A	Traumatic Stress Scale (Norris, 1990)	Clinical interview to assess DSM-III-R PTSD; Perceived Stress Scale	ANOVA	Older persons showed consistently lower rates of PTSD with regards to crime compared to younger people (statistics unreported)	Included past year assessment.	Only limited attention given to crime; high risk of selection bias; high refusal rate;
Tyra (1996)	Community	Case study description of an older rape victim reported by a nurse	Older victim referred to nurse for treatment	Case summary of acute and longer-phase ('in the months that followed'), exact time scales not reported	Not reported	Clinical summary	Not used	Qual.	Acute rape trauma syndrome: disbelief, crying, embarrassment, sleep difficulties, intrusive thoughts, sense of vulnerability, anger. Long-term: fear of going out, fear of staying alone at night, inability to concentrate at work, intense anger, behaviour changes	Detailed, considered changes over time, included follow-up, considered internalising and externalising emotions, recommendations for interventions	Cannot be generalised, standardised measures not used, rape trauma syndrome not included in current DSM or ICD.

									(doors / windows locked, curtains closed)		
Simpson (1996)	Old age psychiatry community clinics	Assessment of impact of crime + 5 case studies on impact in older victims	Convenience sample	Not reported	N/A	Asked if had been a victim	Checklist for DSM-IV PTSD and depression Mini Mental State Examination (MADRS; Impact of Event score	Descriptive	100/ 350 (28.5%) older adults had been victims, of which 5 (5%) had PTSD. Clinical characteristics included depression, insomnia, avoidance, agoraphobia.	Amongst the first to provide data on PTSD in older crime victims in the UK and highlighted need for epidemiological studies; gave recommendations for clinicians	Conducted in one health centre so cannot be generalised; lack of detail in methodology limiting replicability; limited demographic details reported; limited to older adults known to psychiatry services; anxiety not assessed
Spalek (1999)	Community	To explore the impact of financial crime in older victims of Maxwell Pension Scandal.	Purposive sampling of support groups.	Not clearly reported, however, scandal was discovered in 1996 and paper published in 1999.	N/A	Self-reported victim.	N/A	Qualitative, not further details reported.	Themes reported were anger, anxiety, shattered assumptions (Janoff-Bulman, 1985), Anger noted in place of self-blame.	First to consider fraud, in-depth exploration of a specific incident	Limited reporting of qualitative methods including whether one-to-one or focus groups, approach to analysis, reflexive / epistemological assumptions. Deductive

											analytic approach means unanticipated themes may have been missed.
Acierno (2004)	Community	Preliminary evaluation of a video-based intervention for older adult victims of violence.	Through contact with Law Enforcement Victim Advocates (LEVA)	Contacted attempted within 2-3 weeks of the crime	6 weeks	Crime reported to LEVA	Psychotherapeutic and safety planning knowledge quiz, Geriatric depression scale, post-traumatic stress disorder symptom scale, Beck anxiety inventory	N/A - No data on psychological distress pre-treatment collected	N/A- No data on psychological distress pre-treatment collected	Evaluated in intervention table as no pre-treatment data collected	Evaluated in intervention table as no pre-treatment data collected
Brunet (2013)	Hospital	Compare outcomes in older victims of assault and motor vehicle accidents	Access to A&E	Peri-traumatic distress assessed within seven days of the event.	PTSD symptoms assessed at one, six and twelve months after the event	Seeking medical treatment for assault	Peritraumatic Distress Inventory Peritraumatic Dissociative Experiences Questionnaire Clinician-administered PTSD scale	Generalised linear mixed models	Severity of PTSD in older adults is greater after violent assault than motor vehicle accidents; peritraumatic distress is a risk factor for PTSD.	Systematic approach to recruitment and follow-up; investigates possible explanatory pathways to mental health outcomes; approach to missing data reported	Small sample size; low acceptance rate in participants (29%); did not study anxiety or depression
Fredriksen-Goldsen (2014)	Community	Mental health risk factors of transgend	Surveys	Lifetime	N/A	Lifetime Victimisation Scale (D' Augelli &	Centre for Epidemiological Studies Depression Scale	Linear and logistic regression	Transgender older adults reported higher rates of lifetime victimisation than non-transgender LGB	Large sample, understudied population; measure	Recruitment limited to mailing lists, mostly urban areas,

		er older adults				Grossman, 2001);			older adults; victimisation and stigma explained the highest proportion of the total effect of gender identity on health outcomes adults	validated for older adults	assessment of crime brief
McGraw (2014)	Community	Report findings from a nurse-link scheme	Police referral	Nurse visit joint with police as part of initial response to the crime report.	Three months	Police reported distraction burglary	Geriatric Depression Scale, Hospital Anxiety and Depression Scale	Descriptive statistics	Depression was reported by 25% and anxiety was reported by 13% during first visit.	Collaborated with police, used standard measures, set time between crime and assessment.	Follow up data on psychological outcomes not reported, not an RCT.
Cross (2015)	Media release invite from police to known victims	Qualitatively examine experiences in older victims of fraud or attempted fraud	Face-to-face semi-structured interviews	Not reported	N/A	Self-reported receipt of fraudulent email	None	Thematic coding	Victims experienced self-blame, shame, embarrassment, and endorsed victim-blaming myths. Humour was an ineffective coping mechanism serving as a barrier to disclosure.	Explored impact of attempted fraud as well as substantive fraud.	Limited reporting of qualitative methods or analysis. No reflexivity statement.

Iganski (2015)	Community	Secondary analysis on crime survey data to understand who is most affected by racially-motivated hate crime.	Secondary analysis of Crime Survey for England Wales (CSEW)	Previous 12 months	N/A	Data from CSEW	Asked to tick which emotions they had felt	Logistic regression	Older adults at increased risk of reporting internalised emotions but no/minimal increased risk of externalised emotions to racially motivated hate crime but results are non-significant for both. Odds are lower than younger age groups.	Specific analysis of hate crime, within a set time-frame, the CSEW includes victims that did not report to the police, considers internalised and externalised emotions.	Limited detail on older adults, self-report outcome, not assessed for validity or reliability; possibility of under-reporting not considered; large confidence intervals.
Tan (2016)	Community	To explore how crime affects health and quality of life in different demographic groups	Postal survey	Previous 5 years	N/A	Not reported	Not reported	Descriptive statistics	Respondents aged 61-75 reported: stress (20%), sleeping difficulties (10.2%), lack of confidence (14.8%), depression (8%), panic attacks (9.1%) In respondents aged 75+: stress (13.5%), lack of confidence (11.5%), depression (7.7%), panic attacks (7.7%)	Breakdown of older adults into two age groups; good sample size	Low response rate (20%); crime and symptom assessment unclear; studied alongside other demographic groups so limited exploration
Serfaty (2016)	Community	To identify mental health problems in older victims of common	Older victims, identified through police teams, were screened for	Within the previous month	Three months	A crime reported to the police	Kessler-6 (Kessler et .PC-PTSD GAD-2	Chi-square comparison of crime type by caseness at 3 months	Of those who were re-screened, 27.6% were cases on one of the measures. Of these, 88/134 agreed to diagnostic assessment of which 33/80 (40%)	Tested different ways to identify and recruit older victims, conducted intervention	Sample not representative of the general population; small sample size as pilot study.

		crime, provide preliminary data on prevalence, and test feasibility of RCT	symptoms of anxiety, depression, or PTSD one and three months after a crime.						met diagnostic criteria after the crime.	feasibility work, standardised screening tools used.	
Reisig (2017)	Community	Investigating familial ties and behaviour avoidance on depressive symptoms after victimisation	Survey data collected through random digit dialling	Crime over the past year	N/A	Crime (and family ties) assessed through questionnaire designed for the study	Geriatric Depression Scale avoidance, family ties and crime assessed through questionnaires designed for the study	Linear regression	Victims reported higher depressive symptoms and greater behavioural avoidance coping. The link was weaker among participants with strong attachments to their spouse and adult children Criminal victimisation was significantly associated with avoidance coping and strong spousal attachment was negatively associated with avoidance coping	Breakdown of age groups within older victims; followed on from existing research	Avoidance coping not assessed through a validated measure, does not consider physical health as confounder of avoidance.
Qin (2018)	Community	Mental health after a crime in older adults in China	Multi-stage sampling	Lifetime	N/A	Seven item questionnaire developed for the study	The Fear of Crime scale (Ferraro & LaGrange, 1992); The 12-item General Health Questionnaire	Hierarchical regression	254 (56%) reported one or more types of common crime and experience of common crime was significantly correlated. with poorer mental health and constrained behaviour. When	First non-western study, controlled for sociodemographic features and health, analysed stranger-perpetrated and domestic	Low response rate (57%); mental health symptoms treated as a homogenous concept; not broken down into specific

									controlling for sociodemographic characteristics and physical health, common crime victimization was consistently a significant predictor of poor mental health (β = .126, p = .006)	violence crimes separately.	disorders or symptoms.
Tripathi (2019)	Community	Qualitatively explore older male's experience of cybercrime	Through professionals also interviewed who known through local contacts.	Not reported	N/A	Identified through professionals known to the interviewer	N/A	Theoretical thematic framework approach	The crime led to persistent and unresolved feelings of shame, depression and anxiety.	Impact in non-western country.	Limited details reported; brief discussion on impact
Bailey (2020)	Community	To report data from 80 older adults' written responses to a Mass Observation Archive Directive focused on scams	Written responses captured through the Mass Observation Project	Lifetime	N/A	Asked to write free-text response to: "Have you ever been a victim of scam? What happened?"	Asked to write free-text response to: "how did it affect your mental health?"	Thematic	Identified anxiety, victim blaming, and protective behaviour including scepticism, avoiding cold callers, screening contacts/ email.	Cost-effective approach to data collection, written responses facilitate anonymity reducing socially desirable responding.	Limited details of qualitative methods, no reflexivity statement, written responses only; overly white British sample, non-response rates not recorded.
Muhammed (2021)	Community	To investigate the association of crime victimhoo	Data drawn from the Longitudinal Ageing Study in India Wave	Previous 12 months	N/A	In the last 12 months, have you been a victim of a violent	Short Form Composite International Diagnostic Interview (CIDI-SF)	Chi-square and logistic regression	17.70% of older adults who were victims of a violent crime were suffering from depression against 8.52% non-victims.	Large scale nationally representative sample in India conducted in every	Cannot establish causality, self-reported data on crime, sample

		d with depressio n	1 2017-2018, which used multi-stage stratified area probability cluster sampling.			crime such as assault/ mugging/ threat to life/ others? (Yes/no)			Older victims of violent crime had higher odds of suffering depression compared to non-victims. Once socio-economic and health variables were adjusted for, crime victims were 84% more likely to be depressed than non-victims. Older female victims of violent crime had 2.6 odds of suffering depression. Older victims of violent crimes residing in rural areas had higher odds of suffering depression	state/union territory, considered risk factors, used standardised measurement tool for depression.	characteristics for victim sub-set not reported
Kemp (2023)	Community	Secondary analyses of data from the European Commissi on Survey on Scams and Frauds	Stratified random sampling of each EU member state	Scams occurring in the previous 2 years	N/A	Survey asking whether they had experienced 9 types of fraud (yes/no)	Survey asking whether they had felt angry, irritated, embarrassed, or stressed (yes/no)	Multi-level modelling	Psychological impact was greater in all four categories for older adults aged over 65 than younger age groups. Psychological impact was lower in older victims who perceived themselves as financially secure.	Large sample size; considered heterogeneity within older sub-group	Did not use standardised measures; discussion on impact is brief; odds ratios for 65+ age group not reported

*** *p* =< .05; ** *p* =< .01**

Chapter 7: Systematic Review Results: Psychological Intervention Findings

I found four feasibility interventions studies for psychological impact in older victims: two nursing schemes (McGraw & Drennan, 2006; Tyra, 1996), a psychoeducation video (Acierno et al., 2004b), and an adaptation of cognitive-behavioural therapy (CBT) (Serfaty et al., 2016). I found no published data from fully-powered trials, although further testing of the adapted cognitive-behavioural therapy is in progress (Serfaty et al., 2020).

7.1 Crisis Counselling Nursing Intervention (Tyra, 1996)

The first nursing intervention was crisis counselling for an older rape victim (N = 1) delivered alongside medical care (Tyra, 1996). This involved empathetic listening, longer-term linking into social support, and psychoeducation on coping during court proceedings. It was reported that whilst the older victim continued to suffer flashbacks and felt unsafe a year later, crisis counselling meant she was able to continue living independently at home. Standardised outcome measures were not used and, as a case study, the findings cannot be generalised. The aftermath period that crisis counselling was delivered in was not defined, but it is important to note that guidance released since cautions against prematurely intervening before the person has had a chance to recover naturally (NICE, 2018b).

7.2 A 'Nurse-Link' Collaboration Between Police and District Nurses (McGraw & Drennan, 2006)

The second study described a 'nurse-link' collaboration between district nurses (also called 'home visiting' nurses) and police officers in London to assess and address health

and social care needs of distraction burglary victims aged 70 and over (N =77) (McGraw & Drennan, 2006). Of these, 19 (25%) scored positive on the Geriatric Depression Scale and 10 (13%) on the Hospital Anxiety and Depression Scale. Health and social care were co-ordinated for these older victims and follow-up case studies described successful outcomes. Whilst it is not possible to evaluate the effectiveness of descriptive studies, further feasibility research would be worthwhile, as this highlights the possible benefits that could be achieved by embedding support within existing nursing services.

7.3 A Psychoeducation Video (Acierno et al., 2004)

A psychoeducation video was delivered in 'real-world settings' by local police for older victims of violence in South Carolina (USA) and compared to existing advocacy in a pilot randomised controlled trial (*N* = 116) (Acierno et al., 2004a). Participants who received the video had greater knowledge when assessed later that day, but no differences were found between treatment groups on the Geriatric Depression Inventory or Beck Anxiety Inventory at 6-week follow-up. Genuine differences may have been missed as power calculations were unreported, inclusion was based on victim status rather than distress scores, the intervention was delivered within a few weeks of the crime, researchers were not blinded, the randomisation technique was not reported, and missing data was high (29%). Baseline assessment was not conducted so there was no data on pre-treatment psychological distress scores, and knowledge retention at follow-up was not collected so within-groups changes could not be assessed. Further feasibility work addressing these limitations is recommended as a psychoeducation video would be low cost to deliver if found to be clinically effective.

7.4 Adapted Cognitive-Behavioural Therapy (Serfaty et al., 2016)

Serfaty et al., (2016) partnered with local police and a charity, Victim Support, to systematically identify older victims of different crime types within a month of reporting,

and screen for depression, anxiety, and PTSD at one and three months after. As many as 27.6% of older victims were found to have continued distress symptoms at three months post-crime on either the Kessler-6 (Kessler et al., 2003), the Primary-Care Post-Traumatic Stress Disorder Screen (Prins et al., 2004), the GAD-2 (Kroenke et al., 2007) or the PHQ-2 (Kroenke et al., 2003). However, this small feasibility sample was not representative of the general population, so this prevalence estimation is preliminary.

Older victims who continued to screen positive at three months post-crime were offered a diagnostic interview. Of those, 40% met DSM-IV criteria for a psychological disorder, and *N*= 26 participated in a feasibility RCT of modified CBT compared to treatment-as-usual. Modified CBT was found to be acceptable and promising for treating anxiety and depression as measured on the WHO Disability Assessment Schedule (WHODAS-II; Chwastiak & Von Korff, 2003), Beck Depression Inventory-II (BDI-II; Beck et al., 1996), and Beck Anxiety Inventory (BAI; Beck & Steer, 1990). However, the same trends were not observed for PTSD on the Post-Traumatic Stress Diagnostic Scale (PDS; Foa et al., 1997). It is a strength that this study systematically identified, assessed, and treated older victims using standardised measures within a defined timeframe. Further evaluation through a fully powered RCT is needed to determine the efficacy of this treatment for depression and anxiety in older victims, which is now underway (Serfaty et al., 2020).

Table 4: Summary of Findings of Studies Reporting Interventions

First Author (Year)	Country	Study Design	Sample Size (N)	Participants				Intervention	Comparison	Outcome	Findings	Strengths	Limitations
				Crime	Age (Mean)	Gender	Ethnicity						
Tyra (1996)	USA	Case Study	1	Rape	64 (N/A)	Female	Not reported	Crisis counselling Acute: (psycho-education, empathetic listening, reassurance) Long-term: (supporting healthy coping strategies, linking into social support and psycho-education on emotions during court hearing)	N/A	Description	Victim maintained independent living. A year later she reported that flashbacks continued and that she will never feel safe again.	First intervention, holistic, considers acute and long-term coping, example of delivery alongside healthcare	Evaluation not possible as descriptive case study
Acierno (2004)	USA	RCT	116	Violence	55 + (66.9)	66.5% female	53% white	Psycho-education video on healthy coping and safety planning	Existing advocacy services	GDI, BAI	Those who received the video had greater knowledge that day but no difference in depression or anxiety scores were found at 6-week follow-up.	Cost-effective intervention, partnership with local services to identify older victims of recent crimes; use of standardised measures.	Genuine effects may have been missed as i) no power calculation, ii) no baseline measure, iii) participants selected on victim status rather than distress status and iv)

													delivery of intervention within two-three weeks.
McGraw (2004)	UK	Descriptive	77	Distraction burglary	70+ (79)	Not reported	Not reported	Outreach from district nurses to address health and social care needs	None	GDI, HADS	Identified depression in 25% and anxiety in 13%. Positive examples of support discussed.	Outreach provided through existing services; mental health measured used standardised measures	Descriptive study so evaluation not possible.
Serfaty (2016)	UK	RCT	26	Property, fraud, violent crimes	55 (71.7)	55.2% female	86.1% white	Cognitive-behavioural therapy informed victim improvement package	Treatment as usual	WHODAS-II; BDI-II; BAI; PDS	Favourable trends for treating anxiety and depression but not PTSD	Partnered with services; acceptability considered; randomisation procedure reported; researchers blinded;	Feasibility study preventing full evaluation; no talking control;

BAI = Beck Anxiety Inventory; BDI-II = Beck Depression Inventory II; PDS = Post-Traumatic Stress Diagnostic Scale; GDI = Geriatric Depression Inventory; HADS = Hospital Anxiety Disorder Scale ; WHODAS-II World Health Organisation Disability Assessment Schedule

Chapter 8: Systematic Review Discussion

My review was the first to systematically search, narratively synthesise, and quality appraise the existing global literature on psychological impact and psychological interventions in older victims of community crime. I found 21 eligible studies on psychological impact in older victims, four of which included interventions.

My first aim was to synthesise existing evidence on psychological impact in older victims. Whilst studies varied across aims, outcome definitions and included crimes, adverse impacts in older victims were consistently reported. Thirty-one different psychological impacts were identified, with particular emphasis on internalised anxious and depressive symptoms. Initial prevalence estimates that 28% of older victims of different crimes types continue to suffer depression and/or anxiety three months later (Serfaty et al., 2016) is considerably higher than rates for depression (7%) and anxiety (4%) in older people globally (The World Health Organisation, 2017). For violent crime, depressive symptoms were even higher (Muhammad et al., 2021a) and greater PTSD symptoms were reported than in older victims of motor vehicle accidents (Brunet et al., 2013). Depression attributed to victimisation in transgender older adults had a potentially bigger health impact than well-established risks including smoking and obesity (Fredriksen-Goldsen et al., 2014). My findings follow on from earlier physical health studies which found that older victims of violence and burglary are at increased risk of nursing home placement and accelerated mortality (Donaldson, 2003; Lachs et al., 2006). Together, this supports growing calls to acknowledge the impact of crime on older victims as a public health concern (Burnes et al., 2017; Tan & Haining, 2016).

My second aim was to identify existing interventions for psychological distress in older victims. Whilst intervention research is in its infancy, it is encouraging that

modified CBT was acceptable and favourable for treating anxious and depressive symptoms (Serfaty et al., 2016) and that this is now being further tested (Serfaty et al., 2020). This is consistent with NICE guidelines for anxiety and depression (NICE, 2020, 2022) and complements studies in younger victims (Bachem & Maercker, 2016; Hahn et al., 2023). Further evaluation of CBT for PTSD in older victims is needed (M. Serfaty et al., 2016), however, and testing of other recommended treatments such as EMDR (NICE, 2018a) would also expand on findings in younger victims (Rothbaum, 1997). Further feasibility research of the psychoeducation video and nurse-link schemes (Acierno et al., 2004a; McGraw & Drennan, 2006), addressing the limitations identified in my review, is also advised as these may be low-cost to deliver if found to be effective.

Partnering with local healthcare and police services appears promising for timely identification, recruitment, and intervention delivery (Acierno et al., 2004a; McGraw & Drennan, 2006). As not all crimes are reported, and uptake of mental health services is low in both older adults and crime victims of all ages (MacDonald, 2002; McCart et al., 2010; Nair et al., 2019), future research should consider other partnerships to engage older victims not known to these services. This may include faith organisations, as promising results have been found for spiritually-focused group interventions in older female victims of domestic violence (Bowland et al., 2012). Interventions targeted towards social inclusion and enhancing quality of social connections may also be beneficial (Zagic et al., 2021), especially given findings that social support moderates distress in older victims (Reisig et al., 2017). Whilst randomised controlled trials are the gold-standard for intervention research, they require sufficient numbers to achieve statistical power (Cuschieri, 2019). Single case experimental design (or *N*-of-1 trials) have recently been used to test interventions in older adults (Kadri et al., 2022), and may

be more cost-effective, as statistical power can be achieved through repeat-testing fewer participants compared to conventional trials (Brysbaert, 2019).

My third and final aim was to quality appraise the literature so that recommendations to strengthen the evidence-base can be made. Priorities for future research include establishing prevalence rates in representative samples, understanding how different crime types and victim-perpetrator relationships influence outcomes, understanding both the short-term and long-term impact of crime, and further feasibility and evaluation of interventions. Inductive qualitative research is needed to explore whether there are further impacts not yet identified. Few studies discussed externalised emotions such as anger, yet this was found to be an important part of the phenomenology of crime-related PTSD in violence victims aged 18 and over (Andrews et al., 2000). Further research on individual coping across a range of crime types is also recommended as understanding which older victims are most adversely affected may inform effective allocation of resources and development of targeted interventions. Studies should be carefully planned to ensure accessibility to under-served groups (NIHR-INCLUDE, 2020). This may include older victims from ethnic minorities, who do not speak English, who lack trust in statutory services, are without permanent residency, or have mobility or sensory disabilities (Bodicoat et al., 2021).

Consistency of outcome definitions may be improved by adhering to DSM or ICD diagnostic criteria (APA, 2022; WHO, 2021). Use of standardised assessment tools would strengthen study comparability. Validated tools include the Patient Health Questionnaire (PHQ-9; Arroll et al., 2010) or Beck Depression Inventory (BDI-II; Beck et al., 1996) for depression, the General Anxiety Disorder (GAD-7; Plummer et al., 2016) or Beck Anxiety Inventory (BAI; Beck & Steer, 1990) for anxiety, and the Clinician Administered PTSD scale (CAPS; Weathers et al., 2015) for PTSD. Use of the Traumatic Events Scale is also

advised as it can discriminate between people with severe and mild distress to detect which individuals would most benefit from treatment (Sundin & Horowitz, 2002). Standardising assessment and intervention to three months post-incident has been recommended in other trauma populations as it allows time for natural recovery without prolonging suffering in victims with continued symptoms (McNally et al., 2003). This would also build on existing research identified in my review (Serfaty et al., 2020; M. Serfaty et al., 2016).

Poor reporting of research weakens its applicability and credibility (Ioannidis, 2014). Whilst reporting guidelines were not available when many of the studies were published, future research should follow these to reduce missing detail, such as CONSORT for RCTs and STROBE for observational studies (Equator Network, 2023), and JARS-QUAL for qualitative studies (APA, 2018). Researchers should also specify which crimes have been included, when the crimes occurred, and whether the victim had a pre-existing relationship with the perpetrator or not. As older adults range from individuals in good health and living independently to those who are frail and nearing end of life, clarifying which phase of late adulthood the study findings are most relevant to will help inform treatment decisions (Jaul & Barron, 2021). Finally, studies should confirm research ethics approval has been obtained and outline how procedures adhere to ethical guidance for older trauma victims (McGuire, 2009; Seedat et al., 2004). This includes obtaining informed consent, ensuring confidentiality, and safeguarding procedures if a participant were to disclose ongoing abuse (BPS, 2021; Tirone et al., 2014).

8.1 Strengths and Limitations

Systematic reviews are considered the gold standard for research synthesis (Munn et al., 2018). My review was a comprehensive summary of a limited evidence base. Whilst

many studies included have bias risk, I have made recommendations to improve methodological quality. I only included studies published in English due to resource limitations, however, few studies published in other languages were noted during screening suggesting the number of studies missed is likely to have been small. I purposefully focused on peer-reviewed studies, as recommended for reviews with limited resources as non-published studies often have more methodological issues and introduce further bias rather than reduce it (Egger et al., 2003). Although the included studies largely focused on older victims living in the community as this is where most of these crime types occur, understanding the extent and impact of community crime in older people in nursing homes and long-term care facilities may be important to include in further research.

8.2 End of Section Summary and Next Steps

My systematic review aimed to summarise the existing literature on the psychological impact and interventions for older victims of community crime and identify evidence gaps that my subsequent studies could target. The 21 studies that I found varied in focus, but repeatedly reported a negative psychological impact, supporting that this is a concerning issue warranting further research.

My next study aimed to build on this evidence by conducting qualitative research in older victims of different crime types. My review identified a need for this because there is limited knowledge on individual coping within this population and inductive analysis may also identify psychological impacts that have not yet been considered.

Part III: Study II

Coping in Older Victims of Community Crime: A Qualitative Life-Course Study

Chapter 9: Introduction

The existing studies in older victims of community crime consistently reported negative psychological outcomes, confirming the need for improved support for this population (Satchell et al., 2022). However, it should be acknowledged that many older adults cope well with adversity (Ayalon et al., 2021; Brown & Gordon, 2022). Although 28% of older victims were found to suffer continued psychological distress three months after a crime (M. Serfaty et al., 2016), this implies that 72% were not distressed. An initial reaction to negative events such as a crime is common and often proportionate (Horwitz, 2007). Prolonged symptoms are more problematic as they can lead to chronic psychological disorders and reduced quality of life (Youstin & Siddique, 2019). The next step to strengthen evidence in older victims is therefore to explore different coping styles and how these shape psychological wellbeing after a crime. This may offer insight which can be applied by psychological services to help those who are suffering (Gloster et al., 2017).

As almost a million peer-reviewed journal articles have been published on coping (Frydenberg, 2014), I have focused my review on the most relevant concepts, debates and studies. These are ordered into: 1) Conceptualising coping, 2) Coping studies in older crime victims, and 3) Methodological and policy approaches.

9.1 Conceptualising Coping

9.1.1 Coping Definitions

Adverse events like crime become stressful when the person appraises them as threatening and greater than their perceived capacity (Lazarus & Folkman, 1984). Coping is defined as ongoing cognitive and behavioural strategies to manage this distress (Compas et al., 2017; Lazarus & Folkman, 1984). Successful coping means healthy

functioning is maintained ('resilience'; Bonanno, 2004), recovered (Youstin & Siddique, 2019), or improved (e.g., 'post-traumatic growth'; Joseph & Linley, 2005; Tedeschi & Calhoun, 2004). Poor coping amplifies distress and leads to chronic psychiatric disorders and poor quality of life (Youstin & Siddique, 2019). Coping can therefore positively or negatively influence psychological outcomes (Ano & Vasconcelles, 2005; Kucharska, 2019). In summary, people can experience similar adversities but have different psychological outcomes depending on their coping style (Seyburn et al., 2019).

9.1.2 Coping Classifications

There have been numerous attempts in the literature to classify coping styles with the aim of identifying which are helpful or unhelpful (see Compas et al., 2017 for a full review). This approach has been criticised as people's thoughts, feelings, and behaviours rarely fit into mutually exclusive categories, nor is coping typically 'all good' or 'all bad' for mental health (Blum et al., 2012). For example, Lazarus and Folkman (1984) organised strategies into those acting on the problem (problem-focused) and those regulating emotions (emotion-focused). Roth and Cohen (1986) described 'approach-actions' directed towards the threat (e.g., seeking information) and 'avoidant-actions' directed away from the threat (e.g., denial). In practice, individuals are likely to engage in a mix of coping styles (O'Brien et al., 2019). Coping is therefore a multi-faceted dynamic process, best understood within the context of the individual and their specific situation (Blum et al., 2012; Dubow & Rubinlicht, 2011).

9.1.3 Coping in Older Adults: Successful Ageing

Gerontological researchers historically considered older adults to cope poorly with adversity, due to the competing challenges that come with ageing including poor health,

frailty, depleting finances, and withdrawal from social activities (e.g., Disengagement Theory; Cumming & Henry, 1961). This perspective was disputed by prominent studies such as The Berlin Ageing Study, which followed-up a representative sample of older adults aged 70 to 103 years (*N* =516*)* over 5 months, and found that 63% reported high life satisfaction and feeling positive emotions more frequently than negative emotions (Smith et al., 1999). This suggests that poor mental health is not inevitable during ageing and that an intrinsic sense of wellbeing is important for psychological adjustment, even in the 'very old' (Smith, 2001). This was supported by longitudinal research in adults aged 18 to 94, which found that the ratio of positive to negative emotions improves with age (Carstensen et al., 2011).

The successful ageing movement therefore seeks to understand the factors that promote health and wellbeing in late adulthood rather than those that contribute to disease and decline (Antonovsky, 1987; Teater & Chonody, 2020). Whilst definitions vary, successful ageing broadly refers to being emotionally well-adapted in later life alongside maintaining physiological and cognitive health (Urtamo et al., 2019).

9.1.4 The Life-Course Approach

The life-course approach seeks to understand successful ageing by examining how psychosocial factors occurring throughout an individual's lifetime influence health outcomes in late adulthood (Heikkinen, 2011). Childhood and adolescence is considered especially critical because it can influence coping across the entire lifespan (Felix et al., 2014). Poor coping in older adults has been linked back to different adversities in childhood, including physical and sexual abuse (Draper et al., 2008), illness (Kamiya et al., 2013), conflict between parents, bullying, and economic hardship (Nicolaisen & Thorsen, 2014). A dose-response relationship between the number of childhood traumas

and subsequent anxiety and depression in adulthood has been reported (Hovens, 2015). Stress sensitisation theory suggests that early stressors de-sensitise individuals, meaning lower levels of stress are needed to trigger recurrent depression compared to first onset (Harkness et al., 2020; Monroe & Harkness, 2005). This assumes that the relationship between stress and subsequent mental illness is linear (Liu, 2015), and that stress produces a single, homogenous outcome (Petty et al., 2012).

Other studies suggest that early adversity does not inevitably lead to poor mental health in older adults, however, and that it sometimes produces positive outcomes (Kuhlman et al., 2018; MacLeod et al., 2016). High wellbeing and life satisfaction has been reported in older survivors of even extreme repeated childhood trauma, including institutional abuse (McGee et al., 2020), the Holocaust (Greenblatt-Kimron, 2021; Shrira et al., 2011), and forced labour (Höltge et al., 2018). Research in younger adults also suggests that a lack of childhood adversity may be associated with poor psychological functioning in later life (McLafferty et al., 2018). The influence of life experiences on successful ageing in older adults is therefore complex and currently poorly understood.

9.1.5 Emotional Development in Late Adulthood

The Selective Optimisation with Compensation Model (Baltes & Carstensen, 1996) suggests that successful ageing is a goal-orientated process, in which individuals select and optimise their best functions to compensate for their losses. For example, individuals may manage their declining energy by reducing their commitments so that they can focus on those they consider most important. Socioemotional Selectivity Theory suggests these goals become increasingly emotion-focused as individuals approach the end of their lives, such as prioritising their most meaningful relationships (Carstensen et al., 1999; Carstensen, 2021). An awareness of time depleting encourages the individual to reflect

on their life story and develop a narrative that fosters a sense of purpose (Shmotkin & Shrira, 2012; Shmotkin & Shrira, 2013). This may conjure mixed emotions ('poignancy'), which may counter out extreme responses to create emotional stability (Carstensen et al., 2011). As well as helping older adults to manage the ageing process, this may also equip them to deal with other unanticipated stressful events (Palgi et al., 2015; Pals & McAdams, 2004).

The ability to create meaningful life narratives may explain why sufferers of trauma earlier in life can have varying degrees of life satisfaction as older adults (Browne-Yung et al., 2017; Palgi et al., 2015). For example, a study of Holocaust survivors found that those who were able to contextualise their suffering as a past event, and separate it from their present, reported higher life satisfaction in later-life than those who could not (Shrira & Shmotkin, 2008). The Motivational Theory of Lifespan Development suggests that life narratives create a sense of personal agency, which is considered critical for emotional adaptability in later life (Heckhausen et al., 2010). Yet despite the importance of life stories for successful ageing, these have not yet been studied in older crime victims.

9.2 Coping in Older Crime Victims

9.2.1 Existing Studies: Older Victims of Child and Adult Domestic Abuse

Existing evidence in older victims is mainly limited to a few studies on religious and spiritual coping in Christian older female victims of lifetime abuse (Bowland et al., 2013; Bowland et al., 2011; Bowland et al., 2012; Bowland et al., 2015). Qualitative interviews (Bowland et al., 2011) found this both negatively and positively affected participants' relationship with religion and spirituality. Negative coping included difficulty forgiving themselves or others, feeling alienated, feeling abandoned or punished by God, self-

blame, and feeling unworthy. Positive coping included perceiving their experiences as having made them stronger, seeking collaboration with God, not taking life for granted, and hope for the future. This study included older victims of child abuse, supporting evidence that the impact of child maltreatment can last the lifespan. Further analyses (Bowland et al., 2013) found that negative interpretations mediated the relationship between trauma and depressive and anxious symptoms. Together, these findings support that both positive and negative outcomes can arise from adversity and suggest that personal perspective may be a factor.

Bowland et al. (2012) tested a spiritually focused group intervention for older survivors of child abuse, sexual assault, or domestic violence for reducing trauma-related depressive, anxious, or post-traumatic stress symptoms. The intervention provided psychoeducation on the impact of different perspectives, discussed alternative interpretations of spiritual texts, developed a spiritual action plan, and identified sources of hope. The treatment group had significantly lower symptoms on measures of depression, anxiety, post-traumatic stress, and spiritual distress than the control group and gains were maintained at three-month follow-up. However, recruitment, screening and intervention were conducted by the same researcher so they were not blinded, meaning bias cannot be ruled out. These findings provide initial support for a spiritually-focused appraisal-based therapy for older Christian victims, but its applicability to older victims of other faiths or no faith is limited.

9.2.2 Coping Theory in Older Victims of Elder Abuse

Anetzberger (2012) developed a conceptual framework for understanding psychological impact in older victims of elder abuse, which also considers perspective crucial to coping. Perspective is said to be shaped by cultural norms, the nature of the mistreatment,

relationship with the perpetrator, and individual beliefs (Anetzberger, 2012; Yunus et al., 2019). However, the pathways underpinning individual beliefs and perspective were not articulated, and this has been poorly conceptualised in older adults more broadly (Greenblatt-Kimron, 2021; Keating, 2022). The Anetzberger (2012) model is also specific to elder abuse, so its applicability to community crime remains unclear. For example, relationship with the perpetrator is considered important. In elder abuse, this means someone in a close existing relationship or with an expectation of trust (WHO, 2018) whereas community crime is outside of this (World Health Organisation, 2023). Elder abuse is also typically ongoing (WHO, 2018) whilst community crime may be ongoing or single incident (MPS, 2023a). Community crime encompasses many crime types, varying in severity from those considered minor (e.g., petty theft) to serious crimes (e.g., grievous bodily harm) (for definitions see: MPS, 2023a). The perspectives of older victims of community crime on coping are therefore currently poorly understood.

9.3 Methodological and Policy Approaches

9.3.1 Re-framing Older Adult Research

In 2020, The World Health Organisation (WHO) and United Nations (UN) introduced a ten-year global action plan calling on academia to re-frame older adult research towards health promotion instead of disease prevention (UN Decade of Healthy Ageing, 2021-2030). This approach emphasises that good health is not just the absence of a disorder; it is a state of wellbeing enabling individuals to cope with life stressors (World Health Organisation, 2022). Understanding the factors which consistently help people adapt is therefore essential for improving outcomes (Gloster et al., 2017). Viewing health in this way is considered especially important for older adults because although people are

living longer, their additional years are not necessarily spent with good quality of life (Amuthavalli Thiyagarajan et al., 2022). It also aims to counter widespread perceptions of older people as frail and vulnerable, acknowledging their important contribution to society (World Health Organisation, 2022).

9.3.2 The Life-Course Approach in Policy

The life-course approach is central to the UN Agenda on successful ageing, as well as health equality more broadly (WHO, 2018b). This approach acknowledges that all life stages are intricately intertwined with each other and the lives of other people, meaning wellbeing is dependent on risk and protective factors throughout the lifetime (The Minsk Declaration, 2020). Early life experiences are considered especially important as the implications can be wide-ranging and life-long (WHO, 2018b). Accumulative advantage and disadvantage therefore underscores inequalities in older people, but articulation of lifetime trajectories and turning points is needed to better understand the range of coping in older adults (Keating, 2022).

9.3.3 Qualitative Methods

Qualitative interviewing is considered important for conceptualising coping in older adults because it can examine subjective experience within the context of individual events, memories, beliefs, and values (Höltge et al., 2018; Shenk et al., 2009). To date, qualitative research in older victims of community crime has been limited to fraud (Bailey et al., 2020; Cross, 2015; Spalek, 1999; Tripathi et al., 2019). These studies were not specific to coping, although they did identify that seeking social support was helpful (Cross, 2015) whilst anger, self-blame, trivialising their experience, and avoiding online banking was unhelpful (Bailey et al., 2020; Cross, 2015; Spalek, 1999). However, it is not

clear whether these findings are applicable to other crime types. These studies also used deductive analysis, seeking evidence to support existing theories, but there has not yet been inductive analysis, which may identify unanticipated phenomena. Findings were also mixed on whether crime severity (Cross, 2015) or malicious intention (Bailey et al., 2020) is the more distressing aspect. There is therefore a lack of research from the perspective of older victims of different types of community crime (Reisig et al., 2017; Satchell et al., 2022).

9.4 The Current Study

I aimed to conduct qualitative interviews with older victims about how their lifetime experiences shape how they view their crime and how this shapes their psychological wellbeing.

9.4.1 Context from the Victim Improvement Package (VIP) Trial

My role on the VIP Trial included conducting qualitative interviews on help-seeking and mental health service engagement in older victims. I therefore designed the topic guide to address both my PhD research and the help-seeking study. Although seeking formal help from health services or informal help though social support are forms of coping (McCart et al., 2010), I did not examine this in-depth for my PhD as it was being studied elsewhere (Serfaty et al., in prep). In brief, we found that most older victims were reluctant to seek help from their GP for psychological distress attributed to their crime, even when they were signposted by police officers. Barriers to formal help-seeking included beliefs that the crime was not severe enough to warrant help or that doctors would not view it as medical problem, a preference for support from social networks or faith communities instead, concerns they would be prescribed medication, or were

putting strain on NHS resources. This supports that perspective is an important aspect for coping in older victims. Of those who did seek help, few received treatment from their GP, suggesting professionals may share some of these views. My study aimed to compliment the help-seeking study by providing a broader overview of perspective and coping in older victims.

9.5 Research Question

How do older victims' earlier life experiences shape how they perceive and cope with a crime in late adulthood?

Chapter 10: Methods

I conducted one-to-one semi-structured interviews with older crime victims recruited through the VIP Trial and analysed these inductively using reflexive thematic analysis. The VIP Trial was approved by the University College London Research Ethics Committee (UCL REC) on 17th March 2016, which included permission to embed a qualitative study (6960/ 001) (Appendix 4.1). I submitted an amendment request to UCL REC to adapt the topic guide to include older crime victims' earlier life experiences for the purposes of my PhD, which was granted on 24th May 2018 (Appendix 4.2). My study adhered to the APA Style Journal Article Reporting Standards for Qualitative Research (JARS-Qual) (APA, 2018).

10.1 Reflexivity Statement

Reflexivity statements should be described at the beginning of qualitative methods as they provide important context on the design decisions and interpretation of results (Leavy & Gilgun, 2014). They consider the researchers' personal characteristics, interests, beliefs, possible biases, their experiences with and expectations of the topic of interest, and their relationship with the participants (Gilgun, 2015; Leavy, 2014). This helps readers understand the researchers' perspective, which is important for quality control (Berger, 2015). Although quantitative methods seek to eliminate bias, qualitative approaches consider the individual integral to the research process and embrace this, provided it has been considered (Barrett et al., 2020).

I have a BSc in psychology, MSc in forensic psychology, and was supervised on my PhD by mental health professionals, including a consultant psychiatrist and clinical psychologist. I chose to study early life experiences in older victims for my PhD because

I have a broader interest in psychological trauma across age groups. I previously worked for services supporting people with history of offending and street homelessness, and I was aware that many had had difficult childhoods. I therefore expected that older victims who had suffered early adversity would struggle to cope with a crime in late adulthood. However, I also knew of the literature on resilience and post-traumatic growth, but I was uncertain how these seemingly competing psychological theories worked together. My study reflects my desire to better understand 'the bigger picture', at this led me to create a conceptual framework (Section 12.3). Whilst I had some prior expectations, I sought to be guided by the data and aimed to be open-minded to identify unanticipated topics.

I am a white British, 33-year-old, middle-class, able-bodied, and physically healthy cis-female. I was baptised and confirmed into the Church of England but no longer practice and identify as agnostic. Although I strived for impartiality, I acknowledge that my understanding of beliefs will have been influenced by living in a Western society with greater exposure to Christianity. In terms of my own formative experiences, my experiences of being a crime victim include an attempted house break-in aged 16. I remember feeling distressed at the time but I cannot remember how long I felt anxious for. Despite my increased awareness of crime that comes with studying this PhD, I feel safe in my home and neighbourhood. My childhood was happy and stable, although growing up with a severely autistic sibling with behavioural difficulties was often challenging. However, I consider this experience to have developed my communication skills and empathy for others. I believe I had good rapport with older victims in the VIP Trial, including the qualitative interviewees.

Differences in age, life experiences, and crime experiences of the interviewees likely placed my perspective as an 'outsider' (Berger, 2015). Although this can make detection of nuances between themes more challenging (De Tona, 2006), it can be

empowering for groups who are not often given the opportunity to have their voices heard (Berger, 2015).

10.2 Study Setting

My study was embedded within the Victim Improvement Package (VIP) Trial (Serfaty et al., 2020), as described in Chapter 2. I conducted the qualitative interviews between June 2018 and August 2019. Participants were recruited across nine north and east London boroughs: Islington, Camden, Barnet, Enfield, Hackney, Haringey, Havering, Tower Hamlets, and Newham. The VIP Trial selected these boroughs based on demographic diversity and crime rates. Interviews were in-person, either through home visits or at University College London, as preferred by the participant. Interviews were mostly one-to-one, except for three participants who chose to have a family member present.

10.3 Topic Guide

My topic guide is in Appendix 7.1. I aimed to create an interview that ran seamlessly between my PhD questions and the help-seeking questions for the VIP Trial as dividing these into separate sections may have disrupted the flow of participant responding. I did this by ordering the topic guide into before the crime (life experiences), the crime itself (impact), and after the crime (coping and help-seeking). The topic guide was purposefully semi-structured to accommodate unanticipated topics. I asked open-ended questions and aimed to adopt a warm, neutral tone using active listening and a non-judgemental manner.

I encouraged participants to tell their life story narratively. Narrative responding reveals participants' perspectives and identity as they organise their story in the way most meaningful to them, allowing the researcher to examine both inclusion and

omission of information (Yuen et al., 2021). I started each interview by asking '*Where abouts did you go grow up?,'* followed by '*And what was that like?'.* I adopted a 'naïve approach' (Dyche & Zayas, 1995), encouraging participants to describe exactly what their experiences meant to them (e.g., "*What do you mean by a 'normal Jewish upbringing'?"*). The section on earlier life experiences sought to cover family relationships, home life, neighbourhood, school, key life events, previous crimes, and other traumatic events. I allowed participants to tell their story in the order that made sense to them before prompting them to cover aspects they had not yet mentioned (e.g., "*And had you experienced any crime before? What was that like?")*. This achieved an interview that felt conversational rather than a series of questions and answers. If participants appeared to present an overly positive or negative view, I encouraged them to reflect by asking "*Where there any more challenging / any more positive aspects when you were growing up?"*

Once participants had described their life story, I prompted them to describe the crime that had brought them in contact with the VIP Trial by saying: "*Now, let's talk about the recent crime you experienced. Can you describe for me what happened?".* Participants often spontaneously described their reaction when recounting their experience, but otherwise I asked questions such as "*How did you feel?", "What went through your mind?".* I prompted participants to discuss their response over time by asking: "*How did you feel about this over the days and weeks that followed?".* To progress on to a discussion about coping I asked, "*How did you cope?"* Based on whether participants felt they had coped well or poorly with the experience I asked, "*Is there anything about your earlier experiences that you think has influenced how you've coped?".* After discussing coping more broadly, I moved onto the help-seeking component of the interview by asking "*And what about your GP, did you consider speaking to them about what happened?".* Further

details about the topic guide for the help-seeking component are reported in (Serfaty et al., in prep). I concluded the interviews by asking participants if there was anything else that they wanted to share. Finally, I thanked participants for their time and asked them whether they had any questions they wanted to ask me.

10.4 Participants

Eligible participants were older crime victims aged 65 or over who were involved in the VIP Trial through having reported a recent crime to the Metropolitan Police Service (MPS), had consented to UCL contact, and had sufficient command of English to consent to and participate in interviews. Although eligibility criteria set by the VIP Trial filtered which participants came through to three-month follow-up, I overrode this where possible to achieve as much sample variation as possible. For example, domestic violence and carer abuse were an exclusion criteria for the VIP trial, but as I identified two victims of these crimes during re-screening, I included them in my interviews. Severe cognitive impairment as assessed on the Mini-Neuropsychiatric Interview (MINI) was also an exclusion criteria for the VIP trial but eligible for my interviews (capacity to consent was assumed in adherence to the Mental Capacity Act (2005)).

10.5 Sampling

Sample size in qualitative research is widely debated (Baker & Edwards, 2012). Compared to quantitative studies, smaller samples are typically needed as qualitative research focuses on meaning rather than generalisability and depth of experience rather than breadth (Mason, 2010b). Qualitative samples should be big enough to capture different perspectives on a topic but not so large that depth of analysis is compromised (Mason, 2010b). Research funders and journal editors sometimes require a minimum

sample size for qualitative studies; however, this has been criticised for confusing qualitative and quantitative values and promoting bad practice (Braun & Clarke, 2019).

Another common expectation is to base sample size on saturation: the point where collection of new data does not shed any further light on an issue (CASP, 2018; Constantinou et al., 2017; Glaser & Strauss, 1967; Tong et al., 2007a). This concept originates from grounded theory (Glaser & Strauss, 1967), whereas advocates of thematic analysis argue that it has limited meaning and is poorly defined (Braun & Clarke, 2019). It also requires familiarisation and interpretation of the data and therefore cannot be determined in advance of the analysis (Sim et al., 2018). In practice, sample size depends on the focus of the research and should be justified within the context of the study (Braun & Clarke, 2019).

I selected an *a-priori* target sample size of 25-30 to allow for diversity in sociodemographic and crime characteristics without compromising depth of analysis, which is especially fine-grained in life-course research (Bryman, 2012). This number was also achievable within my 15-month recruitment time-frame (June 2018-August 2019). I used purposive sampling, a non-probability sampling technique where inclusion is based on certain criteria to ensure a broad representation of views (Oliver, 2011). The balance of sample characteristics was closely monitored throughout recruitment and missing features actively sought.

I aimed to recruit a diverse sample balanced across:

- *Gender* and *ethnicity*.
- *Different crime types:* I sought a mix of community crimes including property, violent, and fraudulent crimes. During screening, I also identified two older victims who had a pre-existing relationship with the perpetrator. As my literature

review had found that differences in perpetrator relationship may shape outcomes, I included them in my study, but my focus was on community crime.

- *Age:* As older adults encompass several decades and functional states, I aimed to include a spread of ages and physical health needs. Physical health was not routinely recorded for the VIP Trial so was based on anecdotal informational from interviewees. My sample included participants with mobility difficulties, chronic obstructive pulmonary disease, Parkinson's disease, sensory impairments, and interviewees who were active and in good health.
- *Religion*: This was not planned at the outset but it quickly became apparent that this was important, so I amended my sampling criteria to seek diversity across older victims of different faiths and no faith.
- *Psychological Outcomes:* This was based on both my subjective impression of how older victims were coping and screening outcomes on the combined GAD-2/PHQ-2.

  My subjective impression was partly based on how participants felt they were coping, but I also considered non-verbal communication such as tone of voice, body language, and possible omission of information.

  I sought a mixture of outcomes on the GAD/PHQ-2, including following-up older victims who had initially screened negative. My sample therefore included older victims who were: screen positive both times ('continued distress'), screen negative both times ('coping well'), and initially positive, then negative ('recovered'). As screen negative older victims were not routinely followed-up, identifying whether anyone went from negative to positive ('delayed reaction') was more challenging. To address this, letters were sent out by an MSc student to 100 screen negative older adults encouraging them

to contact the VIP research team if they now felt distressed. Although one older victim responded, they continued to screen negative.

- *Living arrangements (e.g., single, co-habitation), previous history of anxiety and depression:* As this data were already collected for the VIP Trial and are considered risk factors for current depression, anxiety, and feelings of vulnerability in older adults (Vink et al., 2008).
- *Perpetrator arrest:* I aimed to include a mix of crimes that had, and had not, resulted in arrest.

10.6 Procedure

During the three-month rescreening visits or telephone calls for the VIP Trial, I explained that I also was seeking participants for qualitative interviews. The advantage of this was that I had already establish rapport. I also followed-up with a subset of initially screen negative older victims. I described the interview purpose, procedure, and offered flexibility around time, location, and having someone present. I asked older victims whether they were interested in participating but clarified that it was not possible to include everyone. Of the 146 older victims I asked, 86% were agreeable to participation. The reasons for declining were busyness, going away, poor health, discomfort with being recorded, or lack of confidence with speaking English.

I followed-up and arranged interviews with a subset of older victims purposively selected to achieve diversity across my sampling criteria. Most interviews (n = 24) were at participants' homes but three were in private meeting rooms at UCL. Most interviews were one-to-one but two participants chose to have their spouse present and one had their daughter present. This support often aided disclosure ("*Well it is all part of your life, dear – tell Jess"* (P6)) and made it possible to include a participant aged 94.

I started interviews by providing participants with information sheets and advising on confidentiality, data storage, and pausing or withdrawing from interviews. I explained there were no trick questions, no right or wrong answers, and that I was only interested in hearing their perspective. I advised that interviews would be recorded with an encrypted Dictaphone so that I could concentrate fully on what they were saying without taking notes. I then asked participants whether they were agreeable to the procedure and asked them to sign the consent form. No participants declined, but if any had they would have been offered more time to consider participating or the option to cancel altogether.

Once consent was obtained, I checked participants were sitting comfortably and asked whether they were ready to start. I then turned the Dictaphone on and recorded the interview. After the meeting, I noted down my immediate reflections. I uploaded audio recordings onto my encrypted UCL personal drive, saved by reference number to ensure confidentiality.

10.7 Transcription

I transcribed six interviews and received help with transcribing the remaining 21 from MSc students and a professional transcriber. I checked a sub-sample of eight transcriptions against the recordings to ensure accuracy and confidentiality; all were found to be accurate. As transcription should only feature the detail required by the research question, standard orthography was used rather than phonetic transcription, which is intended for in-depth linguistic analysis (Kowell & O'Connell, 2004). Names and identifying features were anonymised during transcription. Once transcription was completed, I deleted the audio files.

10.8 Analysis

I analysed the data using thematic analysis, which systematically identifies, organises, and offers insight into patterns of meaning across the data set (Braun & Clarke, 2006). I supported the thematic analysis with narrative case summaries and illustrative quotes. Together, this achieved in-depth exploration of both the breadth and depth of my sample. Although qualitative research is typically described as either inductive or deductive, it often exists on a continuum (Braun & Clarke, 2020). As discussed in Section 10.1, my approach was broadly inductive as I sought to be guided by the data, but my background in psychology meant I had some prior expectations around what might arise.

10.8.1 Thematic Analysis

For the thematic analysis, I iterated between the six steps outlined by Braun and Clarke (2006): data familiarisation, generation of initial codes, searching for themes, reviewing potential themes, defining and naming themes, and producing the final report. I achieved data familiarisation by conducting all 27 interviews, noting reflections after each interview, completing a proportion of transcription and accuracy checks, and reading all transcripts. Coding and theme development was completed using NVivo 12 (QSR International, 2018), a software programme designed for organising, analysing, and reviewing relationships between non-numerical data.

I uploaded each transcript into NVivo and read through them within the software interface. I highlighted interesting quotes and copied these into 'nodes', which I initially gave descriptive names. For example, the quote "*Don't do to others things you wouldn't want done to you"* (P10) was placed in a node labelled '*Treat others how you wish to be treated'*. These nodes formed the basis of codes. I considered the commonalities across codes, and those which were conceptually similar I grouped together under 'parent

nodes' (e.g., '*Treat others kindly'*). This was an iterative process: as I progressed through the transcripts, more nodes and parent nodes were created, and I re-organised some groups. I then considered the similarities across parent nodes (e.g., '*Treat others kindly', 'Unfair that the offender has not been punished')* to create sub-themes ('*Conflict with beliefs')* and overall themes ('*Beliefs and Values').* Regular supervision and the process of writing up the results also helped clarify my interpretation of the qualitative data.

The process of interviewing, transcribing, and thematic analysis also meant I was immersed in the data and had an in-depth understanding of each interviewee's story. Immediately after the visit, I wrote a case summary describing each participant's story and noting my reflections and ideas. I also summarised my overall impression of how they coped with the crime. This was partly based on their self-described perspective, but I also aimed to view interviews critically, so I considered their tone of voice, body language and possible omission of information when forming this impression. I re-visited my case notes while I was reading through the transcripts for the thematic analysis and updated these with any missed information, further reflections, and summary quotes. I drew on these case studies when writing up the thematic analyses and embedded these within the results as illustrative examples of themes and their underlying processes.

10.8.2 A Conceptual Framework

I found that writing my ideas using pen and paper and drawing connections as a 'mind map' helped me to articulate patterns in the qualitative data and conceptualise how my themes fitted together. This created a visual aid, which I then used to link my results with the existing research, supported through supervision and reading of the literature. I present this in the discussion as a conceptual framework (Section 12.3).

10.9 Ethics

My study was approved by the UCL Research Ethics Committee on the 24th May 2018 (6960/001) (Appendix 4.2). I adhered to guidance from the American Psychiatric Association (APA, 2017c), British Psychological Society (BPS, 2021), General Data Protection and Regulation (GDPR, 2016) and the Declaration of Helsinki (World Medical Association, 2013). I completed training on research governance, data protection, research integrity, and good clinical practice.

Signed written consent was obtained for all participants before the interviews (Appendix 5.5-5.6) and kept in secure storage at UCL. An encrypted Dictaphone was used to record interviews and audio files were labelled by participant reference number. Participants' contact details and data were stored on Data Safe Haven, a secure online server which has been certified to IS027001 information security standard and approved by the NHS Digital Governance Toolkit. Qualitative interviews were anonymised during transcription and audio files deleted once transcription was completed.

Coping research raises additional ethical considerations as recalling potentially traumatic events can evoke painful emotions (Seedat et al., 2004). Guidance states that research should not be avoided for this reason as it risks silencing victims; participants should decide for themselves whether they feel able to take part (Perôt et al., 2018). Participants were provided with information sheets and informed of their right to withdraw from or pause interviews, confidentiality and data protection. As the study was embedded within a trial, signposting information was not routinely provided as this could risk biasing the intervention (Serfaty et al., 2020). I discussed any concerns about participants' wellbeing after the interviews with my supervisor, who is a trained

psychiatrist and chief investigator for the VIP Trial. For one participant, it was agreed that I would write to their GP with their consent.

Chapter 11: Results

11.1 Sample Characteristics

I recruited *N* = 27 older crime victims, the characteristics of each are summarised in Table 5. Interviews lasted on average 73 minutes (range 31-132 minutes). Participants were diverse across age range, genders, ethnicity, religion, self-reported health, previous anxiety and depression, and living arrangements. They were mixed on crimes reported, degree of interaction with the perpetrator, and whether medical attention was required. An arrest had been made for only two crimes in the whole sample; all other cases had had no further contact or been closed.

Participants were also varied on GAD-2/PHQ-2 screening outcomes for psychological distress at one month and three months post-crime. Six (22%) were negative both times ('not distressed), twelve (44%) were positive both times ('continued distress'), nine (33%) were initially positive but negative at three months ('recovered'). It was not possible to recruit anyone who was negative at one month and positive at three months ('delayed response'), despite sending letters out to 100 older victims.

Table 5: Characteristics of Each Participant in the Qualitative Sample

P No.	Crime Type	Religion	Gender	Age	Ethnicity	Previous Anxiety or Depression	Living Alone	Health	Arrest	Screen 1 month	Screen 3 months
1	Burglary	Christian - Catholic	F	70	White British	YES	NO	None, but partner had stroke	NO	NEG	NEG
2	Harassment	Christian – C of E	M	71	White British	NO	NO	Diabetes	NO	POS	POS
3	Attempted Burglary	Atheist	M	74	White British	NO	NO	None reported	NO	POS	POS
4	Burglary	Christian	M	70	White British	NO	NO	None reported	NO	NEG	POS
5	Theft from car	Muslim	M	71	Asian Indian	YES	YES	Poor mobility	NO	POS	POS
6	Distraction Burglary	Christian	F	82	White British	YES	NO	None reported	NO	POS	POS
7	Distraction Burglary	Christian	F	76	White British	YES	YES	Diabetes, wheelchair	NO	POS	POS
8	Theft from person	Christian – Catholic	F	65	White British	YES	NO	Poor mobility, COPD	NO	POS	POS
9	Theft from car	Atheist	M	71	White British	NO	NO	Parkinson's Disease	NO	POS	NEG
10	Theft from person	Christian	F	78	Black African	NO	YES	None reported	NO	POS	NEG
11	Criminal damage	Christian – Catholic	F	67	White British	YES	NO	None reported	YES	POS	NEG
12	Theft from car	Christian	F	68	Black African	NO	YES	Poor mobility	NO	NEG	NEG
13	Harassment	Christian	M	65	Asian Indian	YES	YES	Poor mobility	NO	POS	POS
14	Theft and fraud	Christian – Anglican	F	83	White British	NO	YES	Poor mobility	NO	POS	NEG
15	Fraud	Stoicism	M	87	White British	NO	YES	Poor mobility	NO	POS	NEG
16	Theft from car	Atheist	M	76	White other	NO	NO	None reported	NO	POS	NEG
17	Racially/ religious aggravated assault	Buddhism	M	66	White British	NO	YES	None reported	NO	POS	NEG
18	Actual Bodily Harm	Jewish	F	70	White other	NO	NO	None reported	NO	POS	POS
19	Robbery	Jewish	M	72	Other	NO	NO	None reported	NO	NEG	NEG
20	Theft	Christian	F	83	White British	NO	YES	None reported	NO	NEG	NEG
21	Theft	Jewish	F	73	White British	YES	YES	Poor mobility	NO	POS	POS
22	Burglary	No religion	F	94	White British	NO	YES	Poor mobility	NO	NEG	NEG
23	Actual bodily harm	Christian	F	65	Black Caribbean	YES	YES	None reported	NO	POS	POS
24	Racially/ religious common assault	Jewish	M	68	Mixed other	NO	NO	None reported	NO	POS	NEG
25	Burglary	Hindu	F	71	Asian Indian	NO	YES	Breast cancer	NO	POS	POS
26	Fraud	No religion	F	91	White British	YES	NO	Registered blind	YES	POS	POS
27	Theft from car	Christian	F	66	White British	NO	YES	Poor mobility, angioplasty	NO	POS	POS

11.2 Sociocultural Context

Most participants were raised in London or elsewhere in the UK (Kent, Essex, Liverpool, Sheffield, Lancashire, Wales, and Aberdeen). Other participants were from India, Namibia, Ghana, Tanzania, South Africa, Canada, Jamaica, and Poland. Interviewees often spontaneously provided socio-political context when describing their childhood, which included: World War II, communist-ruled Poland, South African apartheid, the Ugandan-Tanzanian war, the Indo-Pakistani war, and the South-West Africa People's Organisation insurgency. Some interviewees had come to the UK to escape conflict, political oppression, torture, or hate crime, whilst others described peaceful upbringings in post-war England.

11.3 Psychological Impact

Older victims described many of the negative psychological impacts reported in my systematic review as well as some additional impacts not yet reported in the literature (e.g., feeling let down, agitated). Positive responses were also described including sympathy, compassion, calmness, and a sense of triumph. Behavioural responses were observed, including avoiding going outside, checking doors and locks, carrying crystals, and praying before and after leaving the house. A summary comparing psychological impact in my qualitative study with my systematic review is available in Appendix 7.2.

Some participants described physical health impacts they felt were connected to the psychological impact of the crime. One described sudden, debilitating back and mobility problems, which she attributed to the stress of being a victim of fraud: "*All of a sudden, I felt I had been hit by a lorry in the middle of the back and I couldn't walk*" (P14). Another reported that their partner suffered a stroke three days after they were burgled:

"*Something caused it. Maybe shock, maybe age. But if you look at the risk factors: low blood pressure, not overweight, exercise, drinks moderately… who knows, can never prove it, can we?*" (P1). I was also informed during a routine follow-up for the VIP Trial that another participant (P6) had passed away a few months after the interview.

Psychological response did not seem specific to crime type as some participants appeared to have coped well with severe crimes, whilst others found comparatively minor crimes (e.g., theft of a disability parking permit) distressing: "*When you hear about older people being beaten to death in their own home, it's not on the extreme side of the spectrum, this could be considered quite minor, but because my mobility is poor the impact on my life was quite major, so I was angry"* (P27). However, some commonalities across crime types were observed. Older victims of harassment expressed exhaustion because the crime was ongoing. Older victims of theft and burglary described feeling fed up with the inconvenience of claiming insurance. Older victims of fraud and distraction burglary expressed emotions indicating self-blame, including shame, embarrassment, and feeling stupid. Three participants reported anti-Semitism, and all felt let down by the police response: "*They saw me beaten and battered but were not terribly bothered. He said, 'I don't see blood', 'no there's no blood but I'm utterly shaken, why do you need to see blood necessarily?'"* (P24). Meanwhile, an older victim who had been threatened with a weapon felt he had been given disproportionate support: "*It may have been the magic word 'knife' as that's all the rage – I had three contacts with the police and psychologists, and they referred me to you. I said 'look- I'm absolutely fine', I don't think they quite believed me, but I was absolutely fine"* (P19).

Two participants (P23, P26) had a pre-existing relationship with the perpetrator, and this appeared to complicate their psychological response to the crime (domestic violence, neighbour fraud). Both expressed anguish for the relationship: "*I'm getting*

dressed and the tears just come down, why did you do this? I keep wanting to know why my son did this to me – why, why, why was it?" (P23). Both also appeared conflicted over the decision to report the crime: "*I had a dream about his two children, each one had a boxing glove on, one of the presents we bought them a few months before, and they were pummelling me in the diaphragm saying, 'why did you want to send our daddy to prison?'"* (P26).

This was one of just two crimes in the sample that had resulted in arrest. This participant expressed guilt about the police getting involved: "*When the word victim came up I felt very uncomfortable… my grandson was telling me 'fraud, he could get' – he seemed to know a lot about it, how many months he might get and here was all the proof, and the detective agreed 'yes we've got a case'"* (P26). However, the other participant was reassured by the police as they were able to explain what had happened: "*They assured me he'd never done anything like [criminal damage] before. He'd been on drugs, very remorseful, completely apologetic, wanted to pay for any damages, sorry for inconvenience to anybody… had I been left thinking he's got lots of previous, doing this stuff all the time, I would've felt differently... I would have felt more unsettled* (P11). In contrast, other participants expressed frustration that their crime report had not progressed: "*It just sat there. Spelt my name wrong. It just sat there, doing nothing"* (P18).

11.4 Thematic Analysis

I identified two main themes on how participants' formative experiences shaped their outlook and coping with crime: 1) Sense of security and 2) Beliefs and values. Sense of security encapsulated how physically safe and emotionally connected to others participants felt during childhood. Beliefs and values covered older victims' moral and philosophic views on their crime, which they often traced back to their childhood. An unanticipated finding was the prominence of religious and spiritual beliefs in older crime victims, although this did not apply to everyone. Themes, sub-themes, and psychological coping are summarised in Table 6. Narrative case summaries illustrating the themes are embedded throughout the results.

Table 6: Thematic Table of Life Experiences and Perspectives

Theme	Sub-Theme	Codes	Psychological Coping[4]
Childhood Sense of Security	Safe home, safe neighbourhood	The world was very safe, now it has changed	Psychological distress
		The world always had safe and unsafe parts	Coping well
		I have previously overcome adversity but Parkinson's Disease has made me less confident	Coping quite well, but slightly more anxious than before
	Safe home, unsafe neighbourhood	I have previously overcome adversity	Coping well
		I have previously been overwhelmed	Psychological distress
	Unsafe home, safe neighbourhood	I have had to learn to cope independently	Emotionally avoidant
	Unsafe home, unsafe neighbourhood	I have previously been overwhelmed	Psychological distress
Beliefs and Values	Conflict with beliefs and values	Direct attack on beliefs (hate crime)	Psychological distress
		Disrespect to authority	Psychological distress
		Treat others kindly	Psychological distress
		Why has this happened when I have followed my faith?	Psychological distress
		Unfair that the offender has not been punished	Psychological distress
		The world is not as safe as it used to be	Psychological distress
	Calmed by beliefs and values	It was in my destiny; I could not have done anything differently	Coping well
		The perpetrator likely has a difficult life	Coping well
		Letting go is a choice	Coping well
		Faith and prayer offer social support	Coping well
		Friends and family offer social support	Coping well
		I knew they didn't want to harm me	Coping well
		It could have been worse	Coping well

11.5 Theme One: Sense of Security

Participants' narratives about their childhood revealed how physically safe and emotionally connected they felt, which appeared to shape how they responded to the crime in late adulthood. Participants could be broadly divided into one of four categories: Safe home and neighbourhood, safe home but unsafe neighbourhood, safe neighbourhood but unsafe home, or unsafe home and neighbourhood.

[4] As described in section 10.5 and 10.8.2, how older victims coped is based partly on their self-reported perception, but I also considered non-verbal communication such tone of voice, body language and possible omission of information to inform an overall impression.

11.5.1 Safe Home and Neighbourhood

Some participants described both their childhood home and neighbourhood as physically and emotionally secure: "*We would play in the woods until we would go 'oh I'm starving' and then run home and get tea"* (P3). This was often coupled with the view that crime was less common then compared to now: *"You didn't hear of any of the problems we have today… I could be at the park until 9, 10, 11 o'clock at night and have no problems"* (P2). For these participants, the recent crime was a sharp contrast with this earlier sense of security and appeared psychologically distressing.

Narrative Example – P8 – Female, 65, Theft of Purse

Description of safe childhood	Perspective since the crime	Psychological response to crime
"*We could play outside until late at night and then run home for tea."*	"*The world has changed.*"	"*I'm wary now, I am. As long as my daughter is with me, I'll go out, but she might say 'mum should we go here?' 'No let's go back home, I've done what I need to do, rather than get in any trouble when you're out."*

Not all participants who described safe homes and neighbourhoods thought the world was more dangerous now: "*I think some of that did go on [back then], this was the 50s and nobody really talked about that sort of thing in those days, we were just told 'don't talk to strangers' so we didn't and nothing ever happened"* (P17). One even thought their neighbourhood was safer now: "*This area used to be called Murder Mile, now it's full of web designers and guys with beards and super speed bicycles"* (P3). These participants seemed less shocked by the recent crime and were able to reflect on how they coped:

Narrative Example – P3 – Male, 73, Burglary

Description of safe childhood	Life experience that shaped perspective (Working as a medic in Somalia)	Perspective on crime
"I have a misty-eyed nostalgic view of my growing up, I could hear the school bell from our kitchen, climb over the back wall of our house, run along the wall, drop into the playground, play until we would go 'oh I'm starving' and would run home and get tea".	*"As an ambulance man I saw people breathe their last, you know. Being around that kind of trauma and emotional distress sinks in, it must do. And those become like the building blocks of your, is it armour?"*	*"I'll spell it out in terms of the perspectives that all my experiences have up until now given me. Having your laptop nicked from your house by some miscreant crackhead is probably a four. It's bad, but it's not a ten."* [Interviewer] *"What's a ten to you?"* *"A ten would be watching your headmaster's head being cut off by some Islamic terrorist when you're eight, as has happened to people".*

This participant also reflected on how he had coped compared to his wife: *"She obviously hasn't had the life I've had. Her mum and dad were quite well-off, went to private school, all of that, she probably had a more sheltered upbringing. For her, a burglary is a world-ending catastrophe. For me, yeah it's horrible in many ways, but it's not a world ending catastrophe. So maybe it's the perspective on those possible outcomes"* (P3). Their differing exposures to adversity were therefore directly attributed to their different perspectives and subsequent coping with the recent crime.

There was another participant, however, whose perspective on the crime and ability to cope appeared to have been impacted by his recent diagnosis of Parkinson's Disease. He described confidently overcoming a burglary when he was younger but was more doubtful about his recent experience:

Narrative Example – P9 – Male, 71, Tools Stolen from Car

Safe childhood home, safe neighbourhood	Confidence with an earlier crime:	Perspective on Parkinson's and recent crime
"My family were kind, fairly normal, I'd have breakfast, go to school, homework, a little football, radio, bed".	*"They'd locked me in the house to stop me from chasing them so the police had to let me out (laughs), that wasn't traumatic, just memorable."*	*"A consequence was feeling that I might be increasingly incompetent about things like locking the car, which diminishes your confidence… it wasn't in any major sense traumatic but I felt a bit stupid for possibly having left the car door open".*

Taken together, different coping styles were observed in older victims who had safe childhood homes and neighbourhoods. For some older victims, the crime came as a shock, which was distressing. Others had been exposed to, or were more conscious of, adversity before the crime happened and appeared more able to put the crime 'into perspective'. However, whilst overcoming previous adversity seemed helpful for building confidence in older victims who otherwise described a safe childhood, this had been eroded by poor health in one older victim.

11.5.2 Safe Home, Unsafe Neighbourhood

Other participants described safe homes, but unsafe neighbourhoods. For example, an older victim raised in Apartheid South Africa: "*I'm white so I was privileged, idyllic house, but that doesn't take into account that you were afraid to talk, growing up with the police watching you, nobody knew what you thought except your parents*" (P18). Others experienced prejudice because of their race: "*Children would call out 'oh don't play with her, she's a bloody Jew', I'll never forget feeling sad about having no one to play with at breaktime"* (P22). These participants often found the support of their families helpful: *"My parents were very compassionate so I think because of that foundation, they helped me*

in an incredible way to cope with a hostile neighbourhood" (P24). Supportive families combined with overcoming earlier adversity in their neighbourhood appeared to help them cope with the recent crime.

Narrative Example – P19 – Male, 72, Armed Robbery of Bike

Safe childhood home	Unsafe neighbourhood	Perspective on robbery at knifepoint	Psychological response
"I had an enjoyable family life, I had friends, I had games".	*"Being Jewish I was attacked so I was used to that, I had a very normal childhood…We either had to run away or fight back a little bit, it was a bit unpleasant but it was a fact of life, it didn't stop us going where we wanted to go".*	*"I have fought in street fights as I've described to you, it probably gives you a little bit of confidence… if they'd waved a gun around I might have felt differently".*	*"I wasn't particularly fearful and I recovered very quickly… I put it behind me, I got on my other bike and went straight back the next day, I wasn't going to let it stop me. My friends and wife said, 'don't go', but no, I've been riding there for fifteen years, it's <u>my</u> river [laughter]".*

It was noted that this participant consciously and intentionally continued with his normal routine in spite of the crime. This is in contrast to P8 who had described feeling safe in her neighbourhood as a child but was now nervous of leaving her home.

Other participants described initially safe neighbourhoods, which abruptly changed with the outbreak of war. This resulted in fear: "*The community was very, very close... it escalated and everywhere now you are scared* (P12) or loneliness: "*They'd all gone and got evacuated, a stark contrast to the life we'd known, I felt an uncomfortable feeling, a loss, that I couldn't put right*" (P26). These participants varied in their exposure to the conflict, with one participant describing extreme circumstances including witnessing genocide, torture, and seeking asylum. The severity of this trauma, possibly compounded by the loss of the community and neighbourhood safety she had previously known,

appeared to have had lasting psychological consequences. She reported struggling to cope with the recent crime, which might be considered minor compared to her earlier experiences:

Narrative Example – P12- Female, 68, Theft of Rear Lightbulb on Car

Safe home, initially safe neighbourhood	Unsafe neighbourhood after political violence broke out	Lasting psychological impact	Perspective on recent crime
"*I grew up with a loving family, not knowing what crime was, in Namibia we're all one community, no one is a stranger… very nice and kind to each other, it's very happy and rewarding for everybody".*	"*It escalated and everywhere now you are scared. At five o'clock everybody is rushing to go back and then at night-time you hear these guns… eventually I asked, 'why everybody the whole day smiling, happy, then 4 o'clock everyone anxious?', he said 'no, you are just a small child, if I tell you, I get into trouble, lose my life'".*	"*Depression, anxiety… it leaves you with a scar... I now live with a situation where I see the dead men, when those days come, you can't stop it".*	*"They tormented me mentally, I was very very very upset, I cried… they just did that to harass you, or torment your brain, hurt me mentally and psychologically, and then off they walk away…"*

11.5.3 Safe Neighbourhood, Unsafe Home

Others considered their neighbourhood safer than their home: "*My mum was unbalanced in lots of ways; I moved out as soon as I could"* (P27). These participants described abuse: "*My mother was a violent woman… but then I got my freedom, getting a job and going to lesbian nightclubs"* (P7) or neglect: "*Nobody bothered with me, even when I was ill, but I just got on with life"* (P22). These participants described learning to cope on their own: "*You just get on with it, you know?"* (P27). When describing the recent crime, I noted these participants often turned down help even when support was available: "*I'm what you'd call really independent, I don't want Victim Support"* (P7). It was my impression that they had developed a sense of independence during childhood because of this lack of support,

which had endured into late adulthood, even though alternative support networks had since been established. For example, in a participant aged 94:

Narrative Example – P22- Female, 94, Burglary

Unsafe home, safe neighbourhood	Lack of support for earlier trauma and having to cope alone	Rejecting help with current crime
"She treated me as a servant, it was awful…Nobody bothered with me, even when I was ill… I'd go ice-skating, dancing… The YMCA, I enjoyed going there to help".	"*The V-2 came down, the bus behind blown up, how that driver kept driving, all the glass came in the window… it was the worst thing that affected me, ill for a week, and now and again it would hit me, suddenly start crying, and my mother didn't really bother even then so you just got on with life… thing is, even now I can't stand fireworks."*	[Daughter]: "*The door was axed and they came and shone a light in her face at 2am. Three occasions you didn't tell us, the police told you to, because they all want you to come back with us".* [Whispering to interviewer] "*I've emailed her GP and social services".* [Older victim]: "*Try not to let it affect your daily life, I can sort of put it at the back of my mind, I suppose."*

11.5.4 Unsafe Home, Unsafe Neighbourhood

One participant (P5) did not feel safe inside or outside his childhood home. He appeared emotional recounting his life story, often repeating how challenging it had been. Although he did not disclose this, it was my impression that he had experienced anxiety and depression before the recent crime. This participant reported his psychological distress had become worse since having his car broken into and throughout our interview, he had home CCTV displayed on the television next to him. Feeling unsafe as a child combined with this recent crime appeared to have had an accumulative effect on his psychological wellbeing.

Narrative Example – P5 – Male, 71, Theft from Motor Vehicle

Unsafe home, unsafe neighbourhood	Emotional life narrative	Perceived the recent crime as making things worse	Psychological response
"*My father complaining, we don't have money, 'let him sleep under the mango tree so he can look out that people don't nick anything', but I'm scared, panicking - in India we've got snakes, tigers, everything – but if I go home they would beat me up like anything."*	"*I've had a rough life, a very rough life."*	"*It's got worse since then, I'm so scared, very scared… it's not freedom, I used to go about nine, ten o'clock outside, you can't do that anymore… you have this feeling 'what's going to happen?'… it's not an easy life".*	"*Scared to go out in daylight since the broken window".* *"I come back, check my car, see if it's ok."* Participant: *"It's better than TV…. You're just occupied, just make sure your car is ok, make sure your house is ok, make sure the people is ok".* Interviewer: "*How much time a day do you spend watching [CCTV]?"* Participant: "*I think about four or five hours, before I fall asleep… when the camera wasn't here I used to sit here and watch the window".*

11.6 Summary of Theme One: Sense of Security

Participants who had experienced very safe (P8) and very unsafe (P5) homes and neighbourhoods were struggling to cope with the recent crime. Participants who described safe homes but some adversity outside of it appeared to cope well (P3, P19), whereas severe previous adversity was overwhelming and had a lasting impact on subsequent coping (P12). Challenges associated with ageing also appeared to have impacted an earlier sense of confidence in one participant (P9). Participants who had unsafe homes but safe neighbourhoods (P22) preferred to cope independently and were reluctant to discuss their emotions, whereas P8 and P5 described their distress in detail.

11.7 Theme Two: Beliefs and Values

Participants often spontaneously referred to their beliefs and values to explain their feelings about the crime. Many referred to how they had been taught to behave as children, either by their parents ("*I grew up in a 'law and order' family, we knew right from wrong"* (P26)) or their faith ("*We were brought up in church – do not steal. If you need something, ask"* (P12)). Psychologically distressed older victims typically described a disconnect between their beliefs and the crime, whilst those who were coping well were calmed by their beliefs.

11.7.1 Challenge to Beliefs and Values

For some participants, the crime was a direct attack on their beliefs and identity. Three Jewish participants (P18, P21, P24) described anti-Semitism: one was assaulted during peaceful activism, another was asked whether he was Jewish before being assaulted whilst out shopping, and the third experienced *"A virulent anti-Semitic rant... the level of abuse, aggression, it's definitely a hate crime"* (P21). These participants recounted multiple incidents of physical and verbal assault motivated by anti-Semitism throughout their lifetime, suggesting these recent crimes were part of repeat victimisation. These crimes were viewed within the context of intergenerational cultural trauma. Two participants described the principle of: *Kol Yisrael Arevim Zeh Bazeh* ('all Jews are responsible for each other') and were seeking justice for the crime: *"Out of communal responsibility towards my Jewish family and Jewish people"* (P24).

For other participants, the crime indirectly contradicted their beliefs and values. Participants commonly referred to respect for authority: "*You were taught to be respectful of authority. You know, a slap across with a ruler or a cane"* (P17). This was especially

relevant as participants were older adults: "*We were always taught when there is an elderly person you go and do bits and pieces for them*" (P12). Another common value was "*Don't do to others things you wouldn't like done to you"* (P10). An older victim of distraction burglary explained why this meant the crime came as a shock: "*I was brought up to be thoughtful and kind to people and it just hadn't occurred to me that someone would do that*" (P6). Her distress was directly attributed to having this belief challenged ("*It destroyed her natural faith"* (P6 Husband), "*It did actually, it really upset me"* (P6)). This also appeared to have affected her on a spiritual level: "*You just think God, how did this happen?*"

Several participants expressed anguish with their faith after the crime: "*I keep crying and asking God 'why am I suffering? I've reached this age and I'm still suffering'"* (P23). Some said they now prayed for safety: "*please give me a sign that I haven't been robbed and thank you very much for looking after me"* (P7) and: "*Thank God when bad things don't happen, I thank God that the window is not broken"* (P5). These older victims appeared fearful that further crimes would happen if they did not pray for protection.

For others, the lack of resolution seemed more distressing than the crime itself. The older victims of anti-Semitism reported that the police had not taken their crime seriously: "*It disturbed me that the police knew I was unconscious, they knew an ambulance had been called… they never checked to see if they admitted me, whether I was dead or alive… he left it to the special officer to take the report [who] can't start an investigation. So it sat there. Spelt my name wrong. It just sat there, doing nothing"* (P18). Others described a contrast between the current police response and their earlier experiences with authority figures. For example, an older victim warmly explained how she had been treated consistently and fairly by her parents and teachers when she was younger. When describing the crime, she expressed anger that the offender had not been punished:

Narrative example – P8 – Female, 65, Theft of Purse

Development of beliefs and values around fairness and consistency from authority figures	Perceived lack of fairness around the crime
"*We used to play 'til 9 o'clock, no problem, and if we were a minute late with dad he'd say 'right you're barred from going out tomorrow', 'why dad?', 'you're a minute late.. there's always the policeman outside, you can always ask the policeman the time' – which was true – 'I expect you dead on 9 o'clock'. That's how it used to be – no, it was perfect my growing up".* *"We used to love it because we used to have this teacher and she used to treat everybody the same. Every year, they used to do a prize and she said 'I will not give a prize to one of my pupils, you either give it to all my pupils or we don't want it because all my pupils to me, are the same' and that was lovely".*	"*I think it's very unfair, never mind the purse, my money was taken, my cards were taken, everything was taken but I had it replaced, but what's he done hasn't been replaced by any authority… the principle of him getting away with it, that to me is very very unfair".*

This participant had also described a subjectively safe childhood and her consistent experience of fairness may have contributed to this impression. The stark contrast between expectation and experience appeared to explain her distress as an older crime victim.

Another participant described a safe childhood but explained how a different crime ten years earlier had already challenged this perception. Her psychological distress appeared to arise because the recent crime supported a new belief that the world is more dangerous than it used to be:

Narrative example – P10 – Female, 78, Theft of Purse

Earlier beliefs on safety in the community	Previous crime challenged this belief 10 years ago	Recent crime in line with new beliefs that the world is more dangerous
"In Ghana, if you see your neighbour's child misbehaving you can tell them off, you can't do that here." *"In Britain before you could leave your front door open, now you wouldn't dare do that! But things have changed everywhere now, I don't think it's safe anywhere in the world."* *"I walked all the way [home] in the night on my own! That's how safe I felt and now when I look back, I think I was crazy for doing that?"*	*"I was robbed at the cashpoint which was really traumatic for me - they don't think about how the victim will feel – I cried a lot at the cashpoint, and what made it worse was about four people behind me saw what was happening, nobody was interested."*	*"The [shop] manager said 'oh it happens all the time' which is true! People steal people's purses, pickpockets all around."* *"I wouldn't say I feel safe, I have to work at it, make sure I don't give anybody a chance... There are vulnerable categories to belong to, isn't it. Elderly, somebody's coming to rob you, you may not have the strength to fight them off, then black – living in this area, there aren't many blacks here."*

When comparing beliefs and childhood safety, the participant who described a very unsafe childhood (P5) may have found the recent crime consistent with their experiences. Similarly, the participant who said, '*nobody bothered with me*' (P22) may have found the recent crime consistent with her belief that people did not care about her. Taken together, beliefs and experiences appear to intertwine to form an overall sense of security.

11.7.2 Calmed by Beliefs and Values

Other participants were calmed by their beliefs and values after the crime. For some, faith offered helpful ideologies. For example, a Hindu participant felt reassured that she could not have anything differently: "*I believe that whatever is in your destiny will happen, no matter, whatever you do*" (P25). Some were understanding towards the offender: "*Maybe they didn't study the Bible to teach them God's love and discipline*" (P12) and acknowledged they may have had a difficult life: "*Buddhism does help you stay calm, he was the one suffering and not me, a man of mental anguish*" (P17). Related to this, one participant explained: "*I choose mercy, not judgement… I've asked God to bring them to a place of facing up to their own responsibility so that they can get their life sorted*" (P4). This participant described emotional neglect as a child but believed Christianity had helped him cope with his emotions earlier in life and with the current crime:

Narrative Example – Male, 70, Burglary

Lack of security in childhood	Finding security through faith	Perspective on crime
"*I grew up quite an angry little boy… there wasn't much physical affection, cuddles, anything like that… a bit regimented, a bit disciplinarian… I could be quite aggressive.*"	"*[The radio] said so many people hear Jesus Christ knocking on the door of their lives saying, 'open the door of your life, your heart up and allow me to come in'. As soon as I heard that, I thought that's what I've never done… So I said a simple prayer 'God, I'm sorry I'm not Christian. Sorry I've done a load of horrible things. Will you please forgive me?' Before I knew it, I broke down, spontaneously, I hadn't a clue what was going on but I was pleased something was going on inside. From that moment onwards, my whole life was drastically, dramatically changed*".	"*I choose to forgive… many people [say] "I'm gonna get my own back' or whatever… it doesn't mean we deny the pain we might feel [but] if we don't forgive, it's like holding on to them*".

Faith was also helpful because of the social benefits it offered and this was sometimes given as a reason for not seeking psychological support: "*If we need support, we talk to certain friends within the church community"* (P4). Benefits were practical as well as emotional: "*[Name] from church has been marvellous.., I can't do paperwork, but she's cleared that all up"* (P7). Christian participants referred to specific friends whilst Jewish participants described the whole community coming together to aid them in their *"communal responsibility"* to achieve justice: *"The Jewish community extends beyond borders; I had phone calls from Toronto and Sydney"* (P18). Prayer was also considered a form of social support: "*It's like talking to the Lord, just like you would a friend"* (P7). Participants found this helpful for emotion regulation: "*If you feel angry, then maybe you pray or have a conversation with God, I feel at peace* (P4) and often felt better after praying: "*I talk to God, I get a lot of assurance from that, I feel more comfortable and relaxed"* (P12). Although non-religious older victims also described social support - "*Obviously I've spoken to friends and family"* (P17) – it appears that part of the benefits of faith beliefs are through enhanced social networks.

Calming beliefs were also observed outside the context of faith. Some older victims expressed sympathy for the offender: "*He was on drugs… but he'd never done anything like it before and was so remorseful, I just thought 'poor devil'"* (P11). Other participants drew on their life experiences. For example, an older victim of burglary who had worked with young offenders commented: "*Why am I not particularly bothered by it? I actually don't believe that anyone is all bad… Most offenders have had pretty ropey upbringings"* (P1). She attributed her confidence to this experience: "*I know they don't want to get caught so they won't hang around and bash you, but I've noticed when I go out [husband] will say 'I'll come too'… he's really, really lost his confidence since the burglary, or the stroke, which was three or four days later, so may or may not have had something to*

do with the shock of the burglary" (P1). Previous experiences appeared to help participants put the crime into perspective, such as P3 who considered his crime minor compared to the suffering he had observed in Somalia. This further supports how both direct experience and beliefs and values may be intertwined to offer an overall sense of security.

11.8 Summary of Theme Two: Beliefs and Values

Taken together, participants often drew on beliefs and values to explain how the crime had affected them. Many had been taught these as children, and they overlapped with their childhood sense of safety. Participants who were distressed felt the crime conflicted with how they believed people should behave, felt let down by the police, saw it as an attack on their identity, or it reinforced a perception that the world had become more dangerous. Participants who were coping well understood the crime within their beliefs and values, turned to social support, or found prayer helpful.

Chapter 12: Discussion

Understanding healthy coping in older victims is essential to better supporting those in distress (Gloster et al., 2017). Accumulative advantage and disadvantage throughout the lifetime can influence perspective, but the pathways underpinning this in older people have previously been poorly conceptualised (Keating, 2022). My study is the first to qualitatively explore life stories on coping and psychological outcomes in older victims of community crime. Participants gave insightful narratives and were diverse in sociodemographic characteristics, cultural backgrounds, crimes reported and childhood experiences. Overall, I identified two central themes which influenced coping in older victims: 1) childhood sense of security and 2) beliefs and values.

12.1 Childhood Sense of Security

Older victims were broadly divided by degree of emotional and physical security in their childhood homes and neighbourhoods. A participant who was severely distressed by having his car broken into also reported having grown up with abusive parents and a dangerous neighbourhood. This example is consistent with stress sensitisation theories, which suggest that previous stress exposure is a risk factor for psychological distress (Harkness et al., 2006; Harkness et al., 2020). However, another participant who was psychologically distressed after having her purse stolen had described her childhood as perfect. Her distress appears more consistent with Shattered Assumptions Theory (Janoff-Bulman, 1989). This suggests that the abruptness and severity of crime can destroy fundamental beliefs about the world as safe, caring and predictable, heightening awareness of vulnerability and mortality (Janoff-Bulman & Morgan, 1994). Together, the

childhoods of these two participants fell on either extreme (very unsafe and very safe) but both were psychologically distressed by their recent crime.

The Steeling Effect (Liu, 2015) explains this contradiction by suggesting that early adversity has a curvilinear relationship with subsequent psychopathology, instead of a linear relationship. In this model, both circumstances inhibit the development of effective coping skills as nominal stress means there is no opportunity to learn whilst extreme stress is overpowering. Moderate adversity is considered sufficiently challenging that the individual is driven to overcome it without feeling overwhelmed, which then teaches them that they can manage. This is consistent with Sense of Coherence Theory (Antonovsky, 1987), which suggests that healthy coping happens in individuals who are intrinsically confident that they can comprehend and overcome life stressors. An example of moderate adversity in my sample includes an older victim of armed robbery who attributed his confidence in managing this to having previously learned to defend himself from bullying.

Another observation in older victims who seemed to be coping well was that their childhood homes were generally supportive, with their experience of early moderate stressors typically outside the home. Attachment theories suggest that consistently sensitive and responsive caregivers create a safe environment, which gives children the security to explore the world and trial different coping strategies ('Secure attachment'; Ainsworth, 1979). The interactions children have with their caregiver also shapes their self-worth and expectations around other people's behaviours, which is important for developing and engaging with future relationships ('internal working models'; Bowlby, 1969). Many participants in my qualitative study found support from friends, family, or faith communities helpful after the crime. This is consistent with the studies in my systematic review, which suggest that social support buffers psychological sequalae in

older crime victims (Krause, 1986; Reisig et al., 2017). However, the older victim suffering lasting psychological trauma from extreme early adversity (political violence) had also left her community behind as a refugee. Attachment Theory and the Steeling Effect may therefore intertwine: secure attachments may build resilience against moderate stressors, helped with ongoing social support, but they may be overpowered by extreme stressors or loss of those earlier connections.

Other participants in my sample reported having abusive or neglectful parents and described learning to cope on their own during childhood. When discussing their recent crime, they were less forthcoming about their emotions and had often rejected support from relatives or professional services. Children with consistently rejecting and neglectful parents may develop avoidant attachment styles (Ainsworth, 1979), which in adulthood has been associated with excessive self-reliance, suppression of negative emotions, and disengagement from stressors (Gillath et al., 2016). Inconsistent parenting can result in anxious attachment styles (Ainsworth, 1979), which are associated with increased threat perception and coping styles which intensify distress, such as rumination (Gillath et al., 2016; Maunder et al., 2006). A large study of community-dwelling older adults (N = 1,061) who reported at least one life-time trauma found that high childhood attachment anxiety or avoidance as measured on the Experiences in Close Relationships Inventory (ECR-S; Wei et al., 2007) predicted post-traumatic stress symptoms, even after controlling for sociodemographic characteristics (Ogle et al., 2015). This supports that insecure attachment styles can disrupt subsequent coping throughout the lifespan.

Taken together, older victims in my sample with extreme childhood adversity or no childhood adversity appeared to cope more poorly than those with moderate experiences. My findings broadly support The Steeling Effect (Liu, 2015) that resilience

develops through exposure to moderate trauma but suggest this needs to be combined with secure attachment. In turn, secure attachment is important for the ability to mobilise and engage with social support.

12.2 Beliefs and Values

Beliefs and values formed in childhood were important to older victims' overall sense of security. Psychologically distressed older victims felt the crime conflicted with their beliefs whilst older victims who were coping well found their beliefs calming.

Park's (2010) Meaning-Making Model suggests that the more an individual perceives a situation as unjust, the more distressed they will be. To restore fundamental beliefs in the fairness of the world (Janoff-Bulman, 1989), individuals instinctively try to understand why the incident arose but recovery will not happen until they have found an explanation that offers resolution or comfort ('meaning'; Frankl, 1946). This process may involve changing their perspective on the situation to fit their beliefs ('assimilation'; Park, 2010) or changing their beliefs to fit the situation ('accommodation'; Joseph & Linley, 2006). Examples of meaning-making in my sample include expressing compassion towards the offender or considering how the situation could have been worse.

Cognitive models propose that negative interpretations can lead to psychological disorders (Beck et al., 1979). If an individual cannot find a meaningful explanation, or they overaccommodate the threat (e.g., older victims who thought the world had become more dangerous), then psychological distress will continue (Ehlers & Clark, 2000). Post-traumatic stress disorder is considered to be rooted in negative beliefs about the dangerousness of the world and feelings of incompetence (Ehlers & Clark, 2000). Depression is underpinned by hopelessness about the world and feelings of unworthiness (Beck et al., 1979) and anxiety by threat overestimation (Clark & Beck,

2010). To cope, individuals are likely to develop unhelpful strategies, which offer short-term relief but reinforce disorders longer-term (e.g., avoidance) (Salkovskis, 1996). Examples of this in my sample include older victims who avoided leaving the house or spent excessive time monitoring home security. Achieving an adaptive sense of meaning is therefore essential to coping well (Frankl, 1946; Hayes et al., 2012).

From a life-course perspective, meaning-making is likely to be powerfully influenced by beliefs formed in childhood. Infants organise new knowledge into 'schemas' (Piaget & Cook, 1954). These develop over time to form interconnected networks which guide attitudes and expectations (Bowlby, 1980; Crawford & Wright, 2007). This reduces the cognitive resources needed to understand daily events, but when information is inconsistent with a schema, it requires more effort to process, which feels psychologically uncomfortable ('cognitive dissonance'; Festinger, 1962). People therefore naturally prefer information which maintains cognitive consistency ('confirmation bias'; Festinger, 1962). Individuals who have developed schemas which can meaningfully explain suffering before they experience it may therefore be more resilient, as they can readily account for the incident with minimal cognitive dissonance (Leo et al., 2021).

Schema development may be influenced by early attachment experiences (Bowlby, 1980). As secure attachments create a safe environment to try different coping strategies, it allows schemas to become more nuanced (Ainsworth, 1979). This is associated with increased cognitive flexibility, the ability to shift mental resources to meet situational demands, to change perspective, and balance competing priorities (Kashdan & Rottenberg, 2010). Older victims who were coping well often used their earlier experience as a frame of reference to compare their current experience to. However, cognitive flexibility can decline in late adulthood (Craik & Bialystok, 2006), as

seen in the older adult who felt Parkinson's Disease had disrupted his earlier ability to cope.

Maladaptive schemas can develop in children whose core emotional needs are unmet (Young et al., 2003), leading to dysfunctional beliefs about the self, the world, and others ('the cognitive triad'; A. Beck, 2006). As people prefer cognitive consistency, they are likely to take stressors such as crime as evidence for their negative beliefs. This reinforces their maladaptive schemas and makes psychological disorders more likely (A. Beck, 2006; Young et al., 2003). In one of the few prospective coping studies, newly appointed firefighters were assessed during training and followed-up four years later (Bryant & Guthrie, 2007). Pre-existing negative beliefs were found to predict post-traumatic stress symptoms, supporting this as a risk factor for poor coping. However, an older victim who described emotional neglect in childhood explained how Christianity had helped him overcome both earlier adversity and the current crime. Building a relationship with God may compensate for poor attachment by providing an alternative secure attachment figure (R. Beck, 2006; Hart et al., 2010). This suggests insecure attachments do not inevitably lead to poor coping in late adulthood if secure connections can be established elsewhere.

Faith may also promote healthy coping in older adults through enhanced social networks (Yoon & Lee, 2007), further supporting findings that social support protects against distress in older victims (Krause, 1986; Reisig et al., 2017). However, some participants struggled to understand how the crime had happened when they had consistently adhered to their religious teachings. In this context, psychological distress may arise through internal 'spiritual struggle' from having their beliefs challenged (Exline et al., 2014). Interpretation of the crime therefore appears as relevant in older victims of faith as in older victims more broadly. A strong desire for retribution was observed in

older victims of anti-Semitism, as well as some non-religious older victims. As less than 6% of crimes in England and Wales currently result in conviction (ONS, 2023b), this may contribute to ongoing psychological distress in this population. However, they also described feeling let down that the police did not acknowledge the harm caused when they reported the crime. This suggests the initial police communication may also be influential in shaping psychological outcomes in older victims.

Taken together, early experiences appear to shape how older victims perceive themselves and the world, which in turn, influences how they coped with the crime. Positive coping included acceptance, forgiveness, compassion, seeking social support (through friends, faith communities, or prayer), or considering worse outcomes. Negative coping included struggling to explain why the crime happened, desire for retribution, feeling abandoned by God, or perceiving the world as more dangerous.

12.3 A Conceptual Framework on the Life-Course and Coping in Older Victims of Community Crime

Drawing connections in the data into a 'mind map' helped me to articulate patterns and conceptualise how seemingly contradictory theories in the coping literature fit together. I have presented this as a conceptual framework (Figure 5), as these are useful resources for therapists, as they can help clarify the thinking styles that may be relevant to a population (Laidlaw et al., 2004). My findings support the Anetzberger (2012) Elder Abuse Model that perspective shapes impact in older victims, but they also offer insight into how perspective is developed throughout the lifespan.

Figure 5: A Conceptual Framework of Life Experiences, Perspective, and Coping with Crime in Older Adults Applied to Coping Theory

	Formative Early Life Experiences	Worldview	Self-Concept	How the Crime Fits in	Outcome	Possible Mechanisms
Safety and fairness (Secure attachment)	"We could play outside until late at night and then run home for tea" (P8) "We were raised to look out for each other and be kind" (P6)	My experiences are in line with my values: The world and the people in it are good and predictable.	I am protected.	The crime is inconsistent with my sense of safety and values. My perspective has been challenged.	Distress	Shattered Assumptions Theory (Janoff-Bulman, 1989) Cognitive Dissonance (Festinger, 1962) Safety – The Steeling Effect (Liu, 2015)
Mixed experiences (Secure attachment)	"I had an enjoyable family life but being Jewish I was attacked" (P19) "We were very very happy… but then it escalated and we were very very scared"	Experiences and values do not always align I have had positive and negative experiences.	I can make sense of this complexity. I am capable and worthy.	The crime does not change my perspective, I can still make sense of this.	Resilience / Recovery	Moderate stress – The Steeling Effect (Liu, 2015) Sense of Coherence (Antonovsky, 1979) Meaning Making (Frankl, 1964; Park, 2010)
		My earlier sense of safety is overpowered by trauma.	I cannot make sense of this, I am overwhelmed.	The crime adds to this, I am even more overwhelmed.	Distress	Extreme stress – The Steeling Effect (Liu, 2015) Stress Sensitisation Hypothesis (Monroe & Harkness, 2005)
Unsafe home, safe neighbourhood (Insecure attachment)	"I was an angry little boy, there wasn't much affection or cuddles but Jesus' love made me feel at peace" (P4) "No one bothered with me even when I was ill, you've just got to get on with things" (P22)	I've found connection elsewhere; the world can be caring.	Religion helps me make sense of the complexity of the world.	The crime does not change my perspective, religion still helps me.	Resilience / Recovery	God as a replacement secure attachment figure (Kilpatrick, 1997)
		I have not found connection elsewhere; the world is uncaring.	I must be independent to survive.	The crime does not change my perspective, I must still get on with things.	Distress (Emotionally Distant)	Early maladaptive schemas (Young, 2003) Extreme stress – The Steeling Effect (Liu, 2015)
Unsafe home, unsafe neighbourhood (Insecure attachment)	"There's snakes and tigers outside but if I go home, they'll beat me like anything" (P5) "I've had a rough life, a very rough life" (P5)	The world is dangerous uncaring and unfair.	I am unsafe and overwhelmed.	The crime is consistent with this, I feel even more unsafe.	Distress	Early maladaptive schemas (Young, 2003) Stress Sensitisation Hypothesis (Monroe & Harkness, 2005)

12.4 Psychological Impact in Older Crime Victims

My study was focused on life experiences on coping; however, I achieved additional insight into how older victims describe their psychological impact, which merits discussion. I observed many of the negative sequalae reported by studies in my systematic review as well as additional consequences not yet identified (Appendix 7.2). Some also reported that the crime had a positive impact (e.g., compassion). Consistent with my systematic review, I observed that some psychologically distressed older victims described protective behaviours (e.g., praying for safety, monitoring home CCTV). In contrast, an older victim who appeared to be coping well consciously decided not to change his routine. One possibility not yet considered in this population is whether these protective strategies are 'safety-seeking behaviours'. These are defined as unnecessary and dysfunctional overt or covert actions intended to prevent, escape from or reduce severity or risk of a potentially threatening outcome (Salkovskis, 1991; Telch & Lancaster, 2012). This is an important target for cognitive-behavioural interventions as these behaviours provide short-term relief for anxiety but can aggravate it longer-term (Helbig-Lang & Petermann, 2010).

Participants varied in health, including older victims with chronic health problems, sensory, mobility, and cognitive impairments. Existing health problems made coping more difficult for some. For example, one reported Parkinson's Disease had eroded his confidence and another explained theft of her disability parking permit made daily activities more challenging. Others had viewed themselves as previously in good health but felt the crime had made this worse, including sudden mobility problems or a stroke a few days later. Whilst these are their perceptions, and causal links with the crime cannot be verified, they are noteworthy as it suggests that crime may have potentially serious health consequences in older victims. However, others did not connect the crime to their health, and there were

also participants with and without pre-existing health problems who were coping well. This supports that many older adults manage well after adversity (Ayalon et al., 2021) and suggests that many of my findings on broader coping processes may also be relevant to other victim age groups.

Two participants had been close to the perpetrator. This appeared to have complicated their psychological response, as they both expressed grief for the relationship and were conflicted by having reported the crime. This supports Anetzberger's (2012) elder abuse model, which considers perpetrator relationship important. As these were not community-crimes, I have included only a brief discussion on this, but my initial findings suggest that further research would be worthwhile.

I aimed to include crimes that had resulted in arrest as well as crimes that had not, but in practice, I found just two participants whose perpetrator had been arrested. Few crimes are resolved in the UK (ONS, 2023b), especially against older people (Brown & Gordon, 2019). My sample therefore reflected many older victims experiences, but important perspectives may have been missed. Some were anguished that the perpetrator had not been reprimanded, and one of the victims whose perpetrator had been arrested felt reassured, so arrest may be important for recovery. However, another participant felt guilty, so it may be more nuanced than this. Studies in rape victims suggest that legal proceedings can result in re-traumatisation (Burns & Sinko, 2023) so further exploration of the different stages of criminal proceedings on psychological impact in older victims is needed.

An unanticipated finding was the extent antisemitism was reported. Reports of antisemitic hate crime and online abuse have increased in recent years in response to escalating tensions between Israel and Gaza (Community Security Trust; CST, 2021, 2023). There are also wider concerns about the extent of religious, racial, homophobic, transphobic, and disability hate crime in the UK (e.g., The Muslim Council of Britain, 2023; Galop, 2023;

Greenfields & Rogers, 2020). Psychological impact may be compounded in hate crime victims compared to non-hate crime victims because of its targeted nature (Benier, 2017). Non-hate victims may be reassured that their experience could have happened to anyone, but hate crime victims cannot escape that the crime happened because of who they are, and that negative stereotypes associated with their identity were used as justification (Craig-Henderson & Sloan, 2003). The adverse psychological impact of hate crime also extends beyond targeted victims to others sharing their identity (Craig-Henderson & Sloan, 2003). In a study of transgender older adults, victimisation and stigma was found to have an even greater health impact than obesity and smoking (Fredriksen-Goldsen et al., 2014). My findings that older victims of hate crime felt dismissed by the police coincides with a recent formal inspection of the police, which concluded that institutional prejudice has led to serious failings in victim care (The Baroness Casey Review, 2023). Further research into the specific impact of hate crime, and how police response shapes outcomes, is recommended.

Taken together, additional factors observed in older victims included behavioural responses, physical health, relationship with the perpetrator, whether the offender was arrested, and hostility towards identity. These support my findings on perspective as it was often how older victims appraised these factors that appeared relevant for coping.

12.5 Implications and Recommendations for Practice and Policy

My findings raise important clinical considerations for primary care and mental health services. As many older victims cope well after a crime, support should be targeted towards those who are distressed. Given the importance of perspective, appraisal-focused talking therapies are recommended. One possibility is cognitive-behavioural therapy, which is well suited to addressing negative interpretations and possible safety-seeking behaviours. This would also build on ongoing intervention work in older crime victims (Serfaty et al., 2020;

Serfaty et al., 2016). Alternatives may include behaviourally-focused treatments targeting cognitive flexibility (e.g., 'Acceptance and Commitment therapy' ACT; Hayes et al., 2012) or integrative approaches focusing on early maladaptive schemas (Schema Therapy; Young et al., 2003). Spirituality and religion is integral to the lives of many older people (Zimmer et al., 2016), and there is often a preference for this to be incorporated into therapy (Stanley et al., 2011). Spiritually-focused interventions may be helpful (Bowland et al., 2012), but as these have only been tested in Christian older females of domestic abuse, generalisability to older victims of other faiths or no faith remains unclear. As my findings suggest that broader coping processes are involved, therapies with stronger existing evidence (e.g., CBT, ACT) are still recommended, but it is essential that delivery is culturally sensitive (d'Ardenne, 2012).

Psychological services should be accessible, appropriate, and responsive to the local communities they serve (Beck et al., 2019). This should include ongoing work to improve knowledge, curiosity and respect for other cultures, and efforts to accommodate patient preferences around therapist gender, ethnicity, and language spoken where possible (D'Ardenne et al., 2005). Asking patients at the outset about their cultural background can offer important context for discussion and help strengthen the therapeutic alliance by communicating respectful interest (Beck et al., 2019). Based on my findings, clinicians should be mindful that religious and spiritual beliefs may shape older victims' experience of distress and coping. They should seek to engage with this therapeutically and not risk alienating patients by neglecting, rejecting, or challenging their beliefs. However, as older victims of faith may not seek out mental health support, a challenge for further research is how to engage this group.

My finding that prolonged psychological distress can arise even from crimes typically considered minor, such as petty theft, also has important implications. This appears to have been overlooked in older victim research and crime victim studies more broadly. As some

older victims felt let down by services whilst others felt they had been given more support than they needed, it may be that researchers, police, and healthcare services hold 'unconscious bias' around which crimes should be supported. This is defined as implicit attitudes that affect behaviour, interactions, and decision-making (Marcelin et al., 2019). It is often based on stereotyping, which is a major contributor to healthcare disparities (Gopal et al., 2021). The help-seeking study conducted for the VIP Trial found that older victims may also share this view, as they often cited crimes they perceived would have been worse as a reason for not approaching services, even though they felt distressed (Serfaty et al., In prep). Psychological support should therefore be based on clinical presentation, instead of assumptions around who most needs it. Researchers should seek to further understand individual differences in responding and how to effectively engage those in need of support.

My findings also have important implications for policing. There are growing calls to implement harm-focused approaches to crime control policy (Greenfield & Paoli, 2013). For example, The Crime Severity Score and The Cambridge High Harm Index use minimum sentencing guidelines to weigh each crime based on how harmful it is relative to other crimes and have been adopted by many police forces across the UK (ONS, 2022c; Sherman et al., 2016). These are said to offer a low-cost standardised metric on the total impact of harm to assist criminal justice agencies in their allocation of resources (Van Ruitenburg & Ruiter, 2023). However, they do not consider individual differences in psychological responding in their weighting of harm. Further consideration of how my findings may be incorporated to develop a more sophisticated harm measure is an important next step to improve justice outcomes in older victims.

12.6 Strengths and Limitations

My study aimed to address a gap in the literature as more research from the perspective of older crime victims is needed (Reisig et al., 2017). This was the first to 1) qualitatively explore older victims of community crimes other than fraud, 2) conduct inductive analyses in this population, 3) consider healthy coping in older victims, in line with the UN (2021) call to action on successful ageing, and 4) apply the life-course approach in older victims. My sample were diverse across sociodemographic characteristics, crime types, and life experiences. Participants had also lived through varied historical events, which can be highly influential on beliefs about life (Laidlaw et al., 2004). Combining thematic analysis with case summaries meant both the breadth and depth of my sample were analysed. My findings informed a conceptual framework which may be a useful resource for researchers and clinicians. This expanded previous older victim models (Anetzberger, 2012), and helps counter ageist portrayals of all older adults as being frail and vulnerable (Ayalon et al., 2021).

Embedding my study within the VIP Trial enabled timely identification and recruitment of a diverse sample of older victims. However, my access was largely filtered by the VIP Trial eligibility criteria. Only older victims who reported their crime to the police were included, whereas an estimated 60-70% of crimes are unknown to the police (Buil-Gil et al., 2021). Given that reporting a crime is considered a healthy coping strategy in itself (McCart et al., 2010), important perspectives of older victims who did not report may have been missed. This may include older victims who lack trust in statutory services, who do not speak English, or who are without a permanent address (Bodicoat et al., 2021). It was also not possible to include older victims of sexual crimes, which may perpetuate the myth that it does not affect this age group (Bows, 2019b; Goldblatt et al., 2022). Older victims living in long-term care were not excluded from the VIP Trial, but they were not identified

in my study either, and the extent community-crime affects this subgroup remains unclear. As the VIP Trial was conducted in London, older victims from other UK cities and rural areas were excluded, who may also have different perspectives (Gordon & Brown, 2023).

Saturation is often considered important for validity in qualitative research (Constantinou et al., 2017; Tong et al., 2007b) but whether this is appropriate remains debated (Braun & Clarke, 2019). Saturation is defined as the point when relationships between categories are comprehensively explained so that a theory can develop (Morse, 2015). As my study produced a conceptual framework for understanding early life experiences on coping in older victims, saturation may be considered to have been achieved. However, life-course studies are unlikely to fully achieve saturation given the diversity of human experience (Braun & Clarke, 2019; Mason, 2010a). My findings give an indication of further factors that may complicate psychological impact that were not explored in-depth, such as physical health and perpetrator arrest. It would not have been possible to have meaningfully covered all of these within a single study without compromising breadth of analyses. However, the benefit of including initial discussions is that they inform where future research may be helpful. My study is therefore intended to be one in a series of studies. The VIP Team are focusing on help-seeking from mental health services (Serfaty et al., in prep) and I am supervising an MSc student to conduct further analyses on older victims' perceptions of police response on psychological responding (West et al., in prep).

12.7 Future Research

Further qualitative research in addition to these planned studies would enrich my findings. This includes detailed exploration of physical health, relationship with the perpetrator, and the criminal justice system on psychological impact. As my study considered a range of crimes, more detailed understanding of appraisals around specific crimes would be

informative. This may include hate crime as it is targeted towards identity (Benier, 2017), stalking as it is ongoing and data is lacking in older people (Bows, 2019b), and distraction burglary as the older victims in my study expressed shame, which may be a barrier to disclosure (Cross, 2015). I have considered the broader applicability of my research, but more detailed comparisons with other victim groups such as younger victims, elder abuse, or domestic violence would also expand on this.

Interviews with older victims who were not included in my study is also important. This includes older victims of sexual crimes, who do not speak English, from a broader range of faiths, without a permanent address, living in long-term care facilities, or in other UK cities, towns, or rural areas. Understanding the psychological impact in older victims who did not report their crime, as well as the barriers and facilitators to reporting, may help inform initiatives to improve mental health and criminal justice outcomes (Brown & Gordon, 2022). As identifying these sub-groups may be challenging, multiple recruitment streams are recommended. This may include partnering with charities (e.g., Victim Support, Rape Crisis, Age UK), primary care, NHS sexual assault referral services, social media, and faith communities. Public and Patient Involvement (PPI) may also offer insight into reaching these populations, as well as ensuring the acceptability of the research (NIHR INVOLVE, 2021).

Qualitative research is also helpful for informing quantitative studies (Gelo et al., 2008). For example, individual differences on psychological outcomes could be further examined using regression models to test predictors of continued symptoms. This may include previous mental health history, socioeconomic status, living arrangements, health, and whether the perpetrator was arrested or not. Further consideration of safety-seeking behaviours and whether they may be associated with psychological distress in older victims is also needed.

As my findings support appraisal-focused interventions, further evaluation in older victims is recommended. Although the VIP Trial is assessing CBT (Serfaty et al., 2020), this will have similar limitations to my study, so further testing in representative samples is needed. Evaluation of alternative interventions is also important, including other appraisal focused therapies (e.g., ACT, schema therapy), spiritually focused therapies, and non-talking therapies such as psychoeducation. As not all older victims seek help, feasibility studies should also explore delivery of intervention. For example, researchers could consider relationship building with leaders of different faiths to explore whether support could be delivered as part of pastoral care.

12.8 End of Section Summary and Next Steps

My qualitative study aimed to target some of the evidence gaps identified in my systematic review. Existing research had consistently reported adverse psychological outcome in older victims but had not qualitatively explored a range of crime types or considered healthy coping. I therefore purposively sampled and conducted in-depth semi-structured interviews with 27 older victims of a mix of sociodemographic characteristics and crime types. As the life-course approach has been recommended to understand coping pathways in crime victims and older people (Gonggrijp et al., 2023; WHO, 2018b), I adopted this and used thematic analysis and case summaries to explore the breadth and depth of the sample. I developed two themes – 'sense of safety' and 'beliefs and values' – and explored how this shaped perspective, which, in turn, shaped coping. My findings informed a conceptual framework of coping and I have made recommendations for policy and practice.

My next study focused in-depth on a specific aspect of coping: safety-seeking behaviours. Both my systematic review and qualitative study have observed older victims

changing their behaviour after the crime (e.g., praying before and after leaving the house) but whether this is helpful or unhelpful for psychological distress has not yet been clarified.

Part IV: Study III

Safety-Seeking Behaviours in Older Victims of Community Crime: A Cross-Sectional Study Including Design and Preliminary Evaluation of a Novel Patient-Reported Measure

Chapter 13: Introduction

13.1 Safety-Seeking Behaviours

Safety-seeking behaviours are defined as unnecessary and dysfunctional overt or covert actions intended to prevent, escape from, or reduce risk or severity of potentially threatening events (Salkovskis, 1991; Telch & Lancaster, 2012). They enhance subjective safety in response to exaggerated perceived threats (Salkovskis, 1991) so are distinct from adaptive behaviours like wearing a seatbelt when driving (Thwaites & Freeston, 2005). Their presentation varies from outright avoidance to subtler behaviours like checking or seeking reassurance (Hoffman & Chu, 2019), and they can be cognitive as well as behavioural (Rachman, 1997). Recent thinking also suggests that they may be a constellation of behaviours rather than a single action (Borsboom et al., 2021). Safety-seeking behaviours differ across people because they reflect the individual's specific concerns (Goetz et al., 2016). They have been categorised into those that block contact with the threat so that anxiety does not rise at all (preventive) and those that reduce anxiety when exposed to the threat (restorative) (Goetz et al., 2016; Helbig-Lang & Petermann, 2010).

Safety-seeking behaviours are considered a key mechanism to cognitive-behavioural theory and have been used to explain persistence of anxiety (Thwaites & Freeston, 2005), depression (Moorey, 2010), and post-traumatic stress disorder (Ehlers & Clark, 2000). These models suggest that negatively appraising a situation creates a sense of ongoing threat, leading to unpleasant psychological symptoms, which are managed through behavioural strategies meaningfully linked to the appraisal ('maintenance cycles'; Ehlers & Clark, 2000). For example, an older victim who has their purse stolen whilst out shopping

may appraise this as meaning that the world has become more dangerous and respond by not leaving the house.

Safety-seeking is dysfunctional because it maintains threat perception (Salkovskis, 1991). Firstly, when feared outcomes do not occur, the individual attributes this to the behaviour instead of the lack of danger (Lovibond et al., 2009). This prevents disconfirmation of beliefs around the likelihood of feared events occurring (Salkovskis, 1996). Secondly, they make anxiety tolerable, preventing it from subsiding naturally (habituation) (Asnaani et al., 2016; Sharpe et al., 2022). Thirdly, they increase self-focus, making the person more aware of their anxiety (McManus et al., 2008). Finally, they may make the feared outcome more likely to happen (McManus et al., 2008). For example, social anxiety studies describe how individuals who are afraid of criticism engage in self-monitoring, which requires self-focused attention, so they may inadvertently appear cold and distant (McManus et al., 2008; Rapee & Heimberg, 1997). In the context of crime, for example, it may be that excessively checking the locks when leaving the house draws attention to it being vacated. Taken together, safety-seeking behaviours paradoxically reduce anxiety in the short-term but maintain or exacerbate it longer-term (Salkovskis et al., 1999).

Disengaging from safety-seeking behaviours is an important target of cognitive-behavioural therapy (Helbig-Lang & Petermann, 2010). However, clinicians often struggle to distinguish between healthy coping and maladaptive behaviours (Hoffman & Chu, 2019). It has also been argued that some safety-seeking behaviours may be beneficial if they help the person confront their fears ('judicious safety-seeking behaviours'; Rachman et al., 2008). For example, carrying a lucky charm may be the difference between an older victim continuing social activities or avoiding leaving the house entirely. To understand whether a behaviour is dysfunctional, its association with psychological outcomes needs clarifying.

13.2 Safety-Seeking Behaviours in Crime Victims

Several studies in my systematic review described older victims changing their behaviour after the crime including avoiding online banking (Tripathi et al., 2019), increasing home security (Qin & Yan, 2018), and avoiding social activities (Reisig et al., 2017). My qualitative study also observed older victims praying for safety before and after leaving the house and spending several hours a day monitoring home CCTV (Satchell et al., 2023). Two studies found an association between crime and protective behaviours (Qin & Yan, 2018; Reisig et al., 2017), but they did not test for an association between behaviours and mental health, making it unclear whether these were helpful or dysfunctional. They also did not ask whether the behaviour had changed since the crime. Qin and Yan (2018) found that nearly all (98.5%) older people engage in protective behaviours but only 56% had been crime victims, so this may have been pre-existing. Reisig et al. (2017) measured avoidance in older victims, but based this on non-engagement in social and sport activities, which could have been due to poor mobility. The extent that the behaviours described in older victim studies reflect safety-seeking behaviours as defined in cognitive-behavioural theory has not yet been considered.

Only three studies to date have examined safety-seeking behaviours in working-age adult crime victims. A cross-sectional survey (N = 92) found that avoidance was associated with post-traumatic symptoms in middle-aged victims of physical and sexual assault (Dunmore et al., 1999). This was followed by a prospective study in a comparable sample (N = 57), which found that avoidance predicted onset and maintenance of these symptoms (Dunmore et al., 2001). Both studies considered avoidance amongst several other factors, so their analysis and interpretation was brief. More recently, a cross-sectional study found that post-traumatic safety-seeking behaviours were common in both university students

with at least one lifetime trauma experience (*n* = 89, mean age = 20) and middle-aged adults with a *DSM-5* diagnosis of current post-traumatic stress disorder (PTSD) (*n = 47*, mean age = 52) (Blakey et al., 2020). However, whilst the sample included victims of physical and sexual assault, it also included non-crime traumas (e.g., car accidents), and as a breakdown by trauma-type was not provided, its applicability to crime victims is unclear.

These studies all created their own measures to assess safety-seeking behaviours but they did not report whether they had been pre-tested for use in crime victims. The two Dunmore et al., (1999, 2001) studies did not provide the full questionnaire and gave limited detail on its psychometric properties, although example items included behavioural avoidance (*'Avoid people who remind you of the situation'),* cognitive avoidance ('*Try to distract yourself from distressing thoughts'*), attempts to feel safe ('*Sleep with lights or radio on'*), and mentally altering memories ('*Imagine other ways in which you could have defended yourself'*). The Blakey et al., (2020) study created The Post-Traumatic Safety Behaviour Questionnaire, which had acceptable-to-good internal consistency and significantly correlated with self-reported and interviewer-rated PTSD symptoms. However, the questionnaire items were specific and often not related to crime victims (e.g., *'Eliminate distractions while driving'*). Both questionnaires also asked respondents how often they engaged in the behaviours but not whether this was a change from before the crime.

Taken together, initial evidence suggests safety-seeking behaviours are associated with increased post-traumatic symptoms in victims of physical and sexual assault, but other victim groups and psychological outcomes need addressing. Safety-seeking behaviours should also be assessed with measures suitable for crime victims as questionnaires of poor or unknown quality waste resources and are unethical (Mokkink et al., 2018).

13.3 Measuring Safety-Seeking Behaviours

It has long-been recognised that improved measurement of safety-seeking behaviours is needed (Telch & Lancaster, 2012). Many tools exist but they share common limitations. Most are for specific disorders such as social anxiety (e.g., Clark, 2005; Cuming et al., 2009; Jose et al., 2003; Turner et al., 1989), or phobias such as presentations (Kim, 2005), storms (Krause et al., 2018), or heart attacks (Eifert et al., 2000). These are therefore not suitable for crime victims and their applicability to other populations is limited.

An exception is the Safety Behaviour Assessment Form (SBAF; Goodson et al., 2016), the first measure across anxiety disorders and PTSD. Tested in students and military veterans, it has strong internal consistency, test-retest reliability, and predictive and discriminant validity (Goodson et al., 2016). However, it does not ask whether behaviours are attributable to a specific traumatic event, and the items are precise yet aim to cover everyone. Some are relevant to crime victims (e.g., *'Check locks on doors and windows'*), but many are not, such as: '*Take it easy when I exercise (or do other activities that require physical exertion) so my heart rate does not get too high'* or '*Check that I can swallow without choking'.* By attempting to apply to everyone, this measure is potentially relevant to no-one.

All existing safety-seeking behaviour questionnaires use specific lists set by the researchers. Even when targeted to distinct populations, they risk missing aspects. For example, '*Drive at least 5mph below the speed limit*' (PTSB; Blakley et al., 2020) may not even apply to all people afraid of car accidents – some may drive at normal speed but only with the radio on, others may avoid driving altogether. Listing examples encourages a misconception that safety-seeking is defined by the behaviour rather than its underlying function (e.g., to avoid) (Hoffman & Chu, 2019). Individuals should instead be asked what they consider to be threatening or dangerous (Gústavsson et al., 2021). Whilst clinical

interviewing can capture this, it is resource-intensive, requires training, and cannot be used to make inferences across samples (Telch & Lancaster, 2012). Psychometrics are important for clinical practice and research because of the comparable data they generate (Balsamo et al., 2019), yet the existing measures in the field appear to be inadequate.

13.4 A Novel Approach to Measuring Safety-Seeking Behaviours

There are two types of assessment tool: nomothetic and idiographic (Allport, 1961). These correspond with the two opposing epistemological positions underlying quantitative and qualitative research, summarised in Chapter 1. Nomothetic measures reflect quantitative values (Ashworth et al., 2019); they use set questions to collect data from many individuals (Lyon et al., 2017). Safety-seeking questionnaires fall into this category, like many in mental health research (Ashworth et al., 2019; Lyon et al., 2017). They are popular because the data enables estimations of group averages, population norms, symptom severity, and diagnostic cut-offs (Ashworth et al., 2019; Meadows, 2022). However, they require rigorous psychometric testing to ensure they measure what they are supposed to ('validity') consistently ('reliability') (Mokkink et al., 2010). They also cannot detect what respondents consider important (Ashworth, 2019), which, as discussed, is crucial in safety-seeking research (Goetz et al., 2016; Gustavsson et al., 2021). Idiographic tools reflect qualitative values and can capture individual perspective (Lyons et al., 2017, Ashworth et al., 2019). An example is a Patient Reported Outcome (PRO), which is defined as any outcome directly reported by the respondent without interpretation from anyone else (Howell et al., 2022). However, their inability to make inferences about populations limits their wider use (Ashworth, 2019).

Patient Reported Outcome Measures (PROMs) may be a solution as they combine quantitative and qualitative methods (Regnault et al., 2017), yet they remain underutilised

despite their many benefits (Black, 2013; Meadows, 2022). PROMs work by asking respondents to describe the problem most affecting them and to score this on a rating scale (Paterson, 1996; Ruta et al., 1994). This collects person-centred data comparable across participants (Cox & Klinger, 2021; Howell et al., 2022; Regnault et al., 2017). An example is the Psychological Outcome Profiles (PSYCHLOPS; Ashworth et al., 2004), which asks respondents to: '*Choose the problem that troubles you most'* (open response) and: '*Score how much has it affected you over the last week?'* (6 point scale 0 'not at all affected' to 5 'severely affected'). The PSYCHLOPS is reported to be acceptable to patients and therapists, sensitive to change, and encourages therapeutic discussion (Ashworth et al., 2019). Over two-thirds of themes identified on PSYCHLOPS were also not found on quantitative comparators (Sales et al., 2018). Whilst its focus on feelings over behaviours means it is not suited to assessing safety-seeking, this highlights the potential benefits of PROM assessments.

The reason PROMs are not widespread is because developing them is complex (Lyon et al., 2017; Sales et al., 2018). Standard reliability and validity tests used to evaluate nomothetic measures do not apply equally to PROMs, despite both measuring theoretical characteristics ('latent variables') (Hawkins et al., 2018; Reeves et al., 2018). For example, as perspective is changeable, test-retest may make a PROM appear unreliable when it may be accurately recording changes (Reeves et al., 2018). Convergent and discriminant validity is also problematic as PROMs are based on something subjective, which cannot be compared to objective or independent assessments (Howell et al., 2022).

Guidance on PROM development is therefore limited, aside from initial recommendations from the Food Drug and Administration (Food and Drug Administration, 2009), who suggest that there is not a single correct method and instead outline points to consider. This presents an opportunity (Ashworth et al., 2019) as feasibility research may strengthen the field (Lyon et al., 2017; Regnault et al., 2017). As a starting point, content

validity is considered the most important (FDA, 2009), and should be established through accumulative quantitative and qualitative evidence (Hawkins et al., 2018). PROMs should then undergo two evaluation phases: 1) Feasibility using exploratory analyses, and 2) Confirmatory psychometrics to establish measurement characteristics (Cappelleri et al., 2014).

13.5 The Current Study

I aimed to develop the first Patient[5]-Reported Safety-Seeking Behaviour Measure (PRSBM) so that I could use it to collect mixed-methods data on possible safety-seeking behaviours in older victims. The purpose of this was to understand the variety of behaviours in older victims and whether they are associated with continued psychological distress.

As this is a new measure, I aimed to pre-test[6] it in a small sample of older victims to ensure its suitability before collecting data in a larger sample. As this novel approach may benefit the wider field, I also aimed to keep its design broad so that it can be applicable in other populations who have experienced adverse events. I also aimed to explore its psychometrics - the recommended first phase of PROM evaluation (Cappelleri et al., 2014) - so that it can then be further developed in future research.

My study therefore had both exploratory and confirmatory aims:

[5] The 'P' in the PROM acronym is 'patients' but this is used in a broad sense as PROMs are equally useful in community settings (Mokkink et al., 2018).

[6] I used the term 'pre-testing' instead of 'piloting' for clarity, as piloting can refer to both testing of a survey instrument (Simkhada, 2004) and a type of feasibility study (NIHR, 2015). Pilot studies are small scale versions of planned bigger studies, especially interventions (Eldridge et al., 2016), whereas feasibility study is the preferred overarching term for whether a project can be done and should be proceeded with (Eldridge et al., 2016). My study is therefore a feasibility study which includes pre-testing of a measure.

1. To design, pre-test, and conduct initial evaluation of the PRSBM (exploratory psychometrics).

2. To describe possible safety-seeking behaviours in older victims (qualitative exploration).

3. To test whether there is an association between possible safety-seeking behaviours on the PRSBM and continued psychological distress on the combined GAD-2/PHQ-2 in a subset of older victims in the VIP Trial who had initially screened positive (confirmatory quantitative analysis).

My hypothesis was:

H_0: There will be no association between behaviours reported on the PRSBM and re-screening outcomes on the combined GAD-2/PHQ-2 in older victims at three month follow-up post-crime.

H_1: There will be an association between behaviours reported on the PRSBM and re-screening outcomes on the combined GAD-2/PHQ-2 in older victims at three month follow-up post-crime.

Chapter 14: Methods

As developing the Patient-Reported Safety-Behaviour Measure (PRSBM) was an iterative process, I begin with a broad overview of my methods before going into fuller detail in the next chapters. My study adhered to reporting guidance for cross-sectional studies (STROBE; von Elm et al., 2007) (Checklist; Appendix 8.1) and the consideration points for PROM development recommended by the Food and Drug Administration (2009).

14.1 Setting

My study was embedded within the VIP Trial (Serfaty et al., 2020), as described in Chapter 2. My sample was older victims who had initially screened positive for psychological distress on the GAD-2/PHQ-2 (Kroenke et al., 2003; Kroenke et al., 2007) within a month of the crime and were being re-screened at three month follow-up. Older victims who re-screened positive on the GAD-2/PHQ-2 were considered to have continued psychological distress whilst those who re-screened negative were considered to have recovered. This meant my study was cross-sectional between-samples in initially distressed older victims three months after a crime.

14.2 Design of the PRSBM

The design of PRSBM is fully described in Chapter 15, and full versions of the questionnaire are in Appendix 8. In brief, the initial version asked about eight types of safety-seeking behaviour: 1) checking, 2) reassurance seeking, 3) rumination, 4) avoidance, 5) rituals, 6) hyper-vigilance, 7) doing things differently, and 8) any other examples. For each, respondents were asked to: A) *Describe their behaviour* (qualitative response), B) *Rate how often they do this* (scale response), C) *Rate how much of a change this is from before the crime*

(scale response) and D) *Estimate how much time they spend doing this weekly* (numerical figure).

The PRSBM underwent multiple rounds of revision. Firstly, through internal review with the VIP Trial Management Group (TMG), which consists of clinical psychologists, psychiatrists, older adult specialists, criminologists, statisticians, and older victims serving as Public and Patient Involvement members (PPI) (INVOLVE, 2021) (Chapter 15; Appendix 8.7). Secondly, through pre-testing in a small sample of older victims (Chapter 16). Thirdly, through qualitative and quantitative analysis (Chapter 17).

14.3 Ethics Approval

After internal review, I had an initial version of the PRSBM approved for pre-testing by the VIP Trial Management Group (Appendix 8.2). The PPI members had given detailed feedback on its usability and acceptability (Appendix 8.7), and I submitted the proposed version to a VIP Trial advisor at Age UK, who raised no objections to its use. I then submitted this to the UCL Research Ethics Committee (UCL REC). I requested REC approval to test both the initial and revised versions (based on participant feedback) until I had a suitable version for data collection in the larger sample. As described in Chapter 2, study procedures for the VIP Trial had already been REC approved and consent forms for data collection and follow-up had already been collected by police Safer Neighbourhood Team officers. My REC submission was therefore an amendment request seeking approval to collect additional data within the existing VIP Trial study procedures for the purposes of my PhD. My REC amendment request was sent on 15th November 2017 and approval was granted on 28th November 2017 (6960/001; Appendix 4.3).

14.4 Pre-testing the PRSBM

I pre-tested the PRSBM in a small sample of older victims from January 2018 to May 2018. After GAD-2/PHQ-2 re-screening, I asked participants whether they were agreeable to helping me test my measure. The advantage of embedding data collection within an existing visit was that rapport had already been established. No participants declined pre-testing; if any had, I would have thanked them for their time and finished the visit. The PRSBM had been printed in advance and was completed by hand.

I adopted cognitive interviewing as recommended for testing new measures (FDA, 2009; Willis, 1999). This involves asking participants to narrate what they are thinking whilst completing the measure, which I noted down on paper along with my own observations. I then asked follow-up questions recommend by Willis (1999):

- What do you think of how the measure looks?
- Can you read the text?
- Do the questions make sense?
- How do you feel about how long it took to complete?
- What do you think the questionnaire is about?
- Do you have any other comments or suggestions?

Answers and observations were recorded on a proforma with sections recommended by Willis (1999): visual, comprehensibility, observations and hesitancy, response burden and acceptability, face validity, and internal mapping[7] (Appendix 8.3). To reduce socially desirable responding, I emphasised that the measure was a work-in-progress and that all feedback was valued. I also timed how long it took participants to complete the PRSBM.

[7] Internal mapping refers to whether the answers given fit in with the questions (Willis, 1999).

Revisions to the PRSBM are fully described in the next chapters. In brief, different types of Likert scale were tried, amendments to question phrasing were made, and both self-completion and researcher-assisted completion was tested. I continued testing until the PRSBM appeared to be working consistently. I did not set an *a-priori* target sample size for pre-testing as the PRSBM was going to be further tested in a larger sample. I instead sought a balance between the PRSBM working well enough for further testing, without taking too many numbers away from my planned larger sample.

14.5 Data Collection in the Larger Sample

I collected data for the larger sample between June 2018 to September 2019. A sample size of 30 to 50 participants is considered reasonable for exploratory psychometrics (Cappelleri et al., 2014). I consulted two statisticians on the sample size needed for my confirmatory analysis who both advised not to set this *a-priori* and instead collect data on as many participants as possible within my recruitment timeframe.

Pre-testing had found that the PRSBM was most accessible to older victims when it was researcher-assisted, so I supported participants to complete the measure. I sat next to them so that we could both see the measure and read the questions aloud. I scored the scales as directed by the participant and wrote their qualitative responses verbatim so that it was recorded without interpretation from anyone other than the participant (Howell et al., 2022). I did not ask participants to feedback on the measure in this phase.

Demands of the VIP Trial meant it was necessary to adapt the procedure midway through. As my role required me to conduct baseline and follow-up visits as well as rescreening, increasing participant numbers meant it became infeasible to travel to everyone. The decision was made to prioritise baseline for home visits as it required signed written consent, which meant rescreening was instead completed over the telephone. I

considered whether to also complete the PRSBM over the telephone, but this would not have been suitable as I had not tested this method during pre-testing. The trial statistician therefore recommended moving the PRSBM to baseline as it was only a few days after rescreening and would maintain the consistency of in-person completion. The trade-off was that my sample would have higher numbers of rescreen positive than rescreen negative participants because of baseline eligibility for the VIP Trial. I considered whether to analyse only the data before this change, but it would have substantially reduced my sample size. The implications of this were discussed with the VIP TMG, who approved this decision.

After completion of each visit, I entered the data into an Excel spreadsheet along with participant ID number, rescreening outcome and sociodemographic data collected earlier in the trial (age, gender, ethnicity, crime type) (Chapter 2). I checked each entry twice for accuracy against the hard version of the PRSBM and an MSc student checked a random 20% of the completed sample and found entry was accurate. I then prepared for analyses by developing a codebook for SPSS (Appendix 8.6) and copying and pasting qualitative data into Word documents which could be uploaded into NVivo.

14.6 Qualitative Analysis

I conducted the qualitative analyses first so that I would not be influenced by the quantitative results. I adopted inductive thematic analysis (Braun & Clarke, 2006) and completed this using NVivo 12 (QSR International, 2018).

I read through each response and assigned descriptive nodes. For example, *'Checking the locks on the doors and windows', 'Check doors and windows', 'That doors are doubled locked'* all went under the node '*Checking locks'* as they were conceptually similar. After describing items, I considered similarities and differences across examples, and grouped similar items under parent nodes. For example, '*Checking locks'* and '*Checking lights are on*

when going out at night' went under '*Checking behaviours when leaving the house'.* Another example '*Checking the windows have not been smashed*' and '*Checking my jewellery is still there'* were grouped into '*Checking behaviours when returning home'.* From this, I considered broader themes – for example, '*Home security*'. As I was conducting analysis, I noted my ideas and used these to form the basis of the write-up (Chapter 16).

14.7 Quantitative Analysis

My statistical analysis plan was developed with support from three senior statisticians.

14.7.1 Variables

My outcome variable was rescreening result on the GAD-2/PHQ-2 at three months post-crime (Chapter 2). I considered whether to use the total scores on the individual measures (continuous data) or rescreen 'positive or negative' on the combined GAD-2/PHQ-2 (binary data). The statisticians advised that although continuous scales offer more detail, binary outcomes would be more useful in clinical practice and would maintain consistency with the wider VIP Trial. Dichotomising variables has been recommended for both mental health and criminological research as it is simpler to interpret which makes it more meaningful for different audiences (Farrington & Loeber, 2000).

My independent variables were behaviours on the PRSBM. As the PRSBM included several behaviours and subitems, the decision on which to analyse were informed through the development process, discussed in Chapter 15. My final analysis plan included six behaviours: checking, reassurance-seeking, rumination, avoidance, rituals, hypervigilance. These were measured on two 7-point Likert scales: '*How <u>often</u> do you do this?*' (*never* to *all the time*) and '*How much of a <u>change</u> is this compared to before the crime?*' (*a lot less than*

before to *a lot more than before*). Whilst this is ordinal data, recent studies recommend treating this as continuous (Robitzsch, 2020).

I included age, gender and crime type as confounding variables, which had been collected by the police during Step 1 of the VIP Trial (Chapter 2). As the list of eligible crimes was extensive (Appendix 2) and some crimes were in small numbers (e.g., arson), it was necessary to organise these into categories: assault, burglary, criminal damage, deceptive crimes (fraud/ distraction burglary), violent theft (robbery/ aggravated burglary), and theft. These categories were agreed during internal review, in the absence of an established classification in the literature, and it is acknowledged that subjectivity was involved.

14.7.2 Software

I explored the psychometric properties of the PRSBM using *R* (R Core Team, 2022), with the support of a statistician. I conducted the confirmatory analyses using SPSS Version 27 (IBM Corp., 2020). Under the variable tab, I set the variable type, labelled the nominal data, and coded the missing data in accordance with my codebook (Appendix 8.6).

14.7.3 Exploring the Psychometric Properties of the PRSBM

I explored the psychometrics of the PRSBM using a new statistical approach called Unique Variable Analysis (UVA) (Christensen et al., 2023). UVA examines whether the scales in a measure are producing similar or distinct information to each other (Christensen et al., 2023). Items providing similar information tend to be highly correlated, so UVA compares every possible pairing of scales and presents these as a figure called Weighted Topographical Overlap (wTO). A wTO of 0.25 or over has been used as a threshold to indicate substantially high overlap in recent studies (Brown et al., 2023). This approach is useful for examining

datasets where it is not yet known how variables relate to each other (Borsboom et al., 2021).

14.7.4 Testing the Association Between Safety-Seeking Behaviours and Continued Psychological Distress

As the outcome was binary (rescreen positive/negative) and the independent variables ('how often', 'change' scales for each behaviour) were continuous, I used logistic regression (Stoltzfus, 2011). I started with univariable logistic regression - separately testing the 'how often' and 'change' scale for each behaviour – to assess their individual association with the outcome. I then tested for confounding by adjusting for gender, age, and crime type. Variables significantly associated with psychological distress at $p < .05$ after adjusting for gender, age, and crime type were selected for further testing. I then used multivariable logistic regression to compare their association with psychological distress against each other. Backwards elimination set to $p < .05$ was used to remove the variables with the weakest associations so that only the most strongly associated variables remained.

I ensured throughout that the assumptions of logistic regression were met (Field, 2013; Stoltzfus, 2011). The assumption that the outcome data is independent was met as my sample is cross-sectional between-samples, with no repeat measures. I checked for outliers using the SPSS output and considered these when interpreting results. I also checked that the independent variables were not too highly correlated ('multicollinearity') using diagnostic statistics in SPSS. A variance factor below 10 and tolerance figure above 0.2 is considered acceptable (Field, 2013). However, although these were found to be within acceptable limits, the Unique Variable Analysis suggested that the 'how often'/'change' variables within each behaviour were highly correlated with each other (Chapter 17). I therefore adopted a cautious approach and tested 'how often' and 'change' variables separately in the multivariable logistic regression.

14.7.5 Non-Response and Missing Data

The PRSBM included a screening question for each behaviour ('*This is something that I do'* (yes/no)). Participants who selected 'no' were instructed to skip sub-items for that behaviour and move onto the next page. These non-responses were not considered missing data, as it was an instruction built into the PRSBM design. They were instead coded on the 'how often' scales as -3 (never) and on the 'change' scales as 0 (no more or no less than before), as these were the equivalent to not engaging in the behaviour. This procedure preserved my sample size.

Data was considered missing if participants had selected 'yes' but left the scales blank. These were coded as 999 as this value could not occur elsewhere in the dataset. It is debated how much missing data is acceptable, but 5% or below is usually considered inconsequential (Schafer, 1999). As the final PRSBM was researcher-assisted, only 3% of data were missing. These cases were removed by SPSS and the analysis was conducted without them ('listwise deletion') (Hawthorne & Elliott, 2005). If 6% or more had been missing, I would have compared the sample characteristics of those with missing data to those with complete data, to assess whether data was missing at random or not (Rubin, 1976). Data missing at random is considered 'ignorable' (Little & Rubin, 1987), although the reduced sample size is a limitation (Hawthorne & Elliot, 2004). If data are missing not at random, or randomness is unknown, imputation is recommended (Hawthorne & Elliott, 2005).

Outcome data on the GAD-2/PHQ-2 was not expected to be missing as the PRSBM was only completed in participants who had already been re-screened at three months post-crime. The confounding variables were also expected to have low missing data as this was key information obtained by the police during the initial crime report (Chapter 2).

Chapter 15: Design

15.1 Population

My study focused on older victims of community crime. However, keeping the PRSBM's applicability broad means other researchers can make use of it in the future. My questions therefore referred to a '*Bad thing that happened*' rather than a crime, so that the eventual population can be adults aged 18 and over who have had an adverse or traumatic experience. My measure was not intended for children or adolescents, or people with cognitive impairments, communication difficulties, or who do not speak English, as this involves adapting an already established measure (Food and Drug Administration, 2009).

15.2 Item Generation

Items for the PRSBM were informed through the existing literature, my systematic review and qualitative study, and expert feedback from the VIP TMG and PPI members (Appendix 8.7). I drafted a list of possible safety-seeking behaviours (*e.g., Avoiding online banking, praying before and after leaving the house*) and presented this at a trial management group meeting. An in-depth discussion about the purpose of these behaviours was had, and we agreed to draft and test a measure based on six underlying functions: 1) checking, 2) reassurance-seeking, 3) rumination, 4) avoidance, 5) rituals, and 6) hypervigilance. These functions have all been extensively discussed in the cognitive-behavioural literature, including in recent trauma studies (Lac, 2023; Manrique-Millones et al., 2023; Wild et al., 2020). A seventh function '*Doing things in a different way'* was later added, as a PPI member reported that they had started wearing a bag that went across their body since the crime. It was also agreed an '*Any other examples*' question should be included to capture

unanticipated functions. This created eight behaviours overall, a summary definition of each is provided in Table 7. The order these behaviours were presented in the PRSBM was selected at random.

Table 7: Definitions of Safety-Seeking Behaviours Included in the PRSBM

Checking	Checking, in this context, refers to excessive checking of the external environment (Strauss et al., 2020). Individuals repeatedly check when they are unsure that potential harm has been reduced or removed, even when they are aware this may not be rational (Rachman, 2002).
Reassurance-Seeking	Reassurance-seeking is defined as repeatedly asking for safety-related information from others about an issue of concern, despite have already received this information (Parrish & Radomsky, 2010).
Rumination	Rumination is defined as repeatedly thinking over past or future situations, with exaggerated focus on problematic details, to try and feel in control (Dugas et al., 1998; Nolen-Hoeksema, 2003). This was included as safety-seeking behaviours can be cognitive as well as behavioural (Rachman & Hodgson, 1980).
Avoidance	Avoidance is defined as constant and persistent attempts to evade stimuli associated with feared events including external factors (e.g., people and places) and internal factors (e.g., memories) (Perrotta, 2019). It has previously been reported in older victims (Tripathi et al., 2019; Reisig et al., 2017) and working-age victims (Dunmore, Ehlers & Clark, 2001).
Rituals	Rituals was included as my PhD study observed older victims reporting praying for protection before and after leaving the house (Satchell et al., 2023). A broad term was used to cover both religious (Yaden et al., 2020) and non-religious practices, such as superstition (Poonam & Tripathi, 2023).
Hypervigilance	Hypervigilance is defined as a heightened tendency to allocate attentional resources to stimuli in the environment with the aim of detecting threat (Bar-Haim et al., 2007).
Doing things in a different way	This was recommended by a PPI member who reported that they had started wearing a bag across their body.

Any other examples	A miscellaneous question, intended to capture unanticipated behaviours.

For each of these behaviours, it was agreed that respondents should be asked to: 1) rate how *often* they engage in the behaviour, 2) describe their specific behaviour, 3) estimate how *frequently* they do this each week, and 4) rate how much of a *change* this is since the crime. Including free-text descriptions of behaviours ensured the PRSBM was participant reported. Rating both 'how often' and 'change' separately was considered important, as pre-existing behaviours may score highly on 'how often' but not on 'change' whereas those attributed to the crime may score highly on 'how often' *and* 'change'. Including 'frequency' was recommended as future researchers could use it to examine within-person changes (e.g., across therapy sessions).

15.3 Response Options

I phrased the PRSBM using declarative, gender-neutral statements in the first person (e.g., '*There are things I check regularly*'; '*The thing I check is*'). I aimed to use simple language, which I checked against the Flesch Readability Test (score: 87.7, 'easy to read'[8]) and the VIP TMG and PPI feedback (Appendix 8.7). I provided qualitative examples underneath the main questions, as recommended for PROMs to give respondents structure (Cox & Klinger, 2021), using the initial list of possible safety-seeking behaviours. These examples were crime-related rather than general prompts to ensure sufficient data for my main research questions, and I acknowledge that they would need revising in future research to broaden their applicability.

[8] The Flesch Readability Test is a system for determining the comprehensibility of written material based on the average number of words in the sentence, average number of syllables in the words, and how personal the language is (Flesch, 1948). I obtained the score through Microsoft Office 2016 and interpreted this using: http://www.readabilityformulas.com/flesch-reading-ease-readability-formula.php Accessed on 01.03.2019.

15.4 Rating Scales

The VIP TMG initially recommended visual analogue scales. These are lines of fixed length with words indicating extreme ends, with respondents instructed to mark the point on the line they feel most aligned to (FDA, 2009). The 'how often' scale ranged from '*never*' to '*all the time'*. The 'change' scale ranged from '*a lot less than before'* to '*a lot more than before'*. Other types of rating scale were trialled during pre-testing, discussed in Chapter 16.

15.5 Format

I designed the PRSBM on the computer so that it could be printed and completed by hand. I listed each behaviour question (e.g., '*There are things that I check regularly'*) in bold, followed by examples and sub-items. Each behaviour and their corresponding items were on separate pages so that they could be in large font, as some older victims may have poor eyesight. This was also to reduce participants repeat-selecting the same answers across scales as they were spread across pages.

15.6 Respondent Instructions

The useability and acceptability of the measure was assessed by two PPI members before pre-testing (Appendix 8.7), who recommended minor amendments but largely found it self-explanatory. It was agreed with the VIP TMG that both self-completion and researcher-assisted completion would be tried during pre-testing.

15.7 Version Approved for Pre-Testing

The VIP TMG and PPI members provided feedback on face validity, comprehensibility, and accessibility (Appendix 8.7). This PRSBM was refined based on this feedback and re-submitted until the TMG and PPI members approved a version for pre-testing, subject to

approval from the UCL Research Ethics Committee (received on 28th November 2017) (Appendix 4.3).

An example page of the approved PRSBM is presented in Figure 6, followed by a summary overview of all questions in the PRSBM in Figure 7. Full versions of the PRSBM before and after pre-testing are in Appendix 8.

Figure 6: Example Page of the PRSBM Approved by the VIP TMG for Pre-Testing

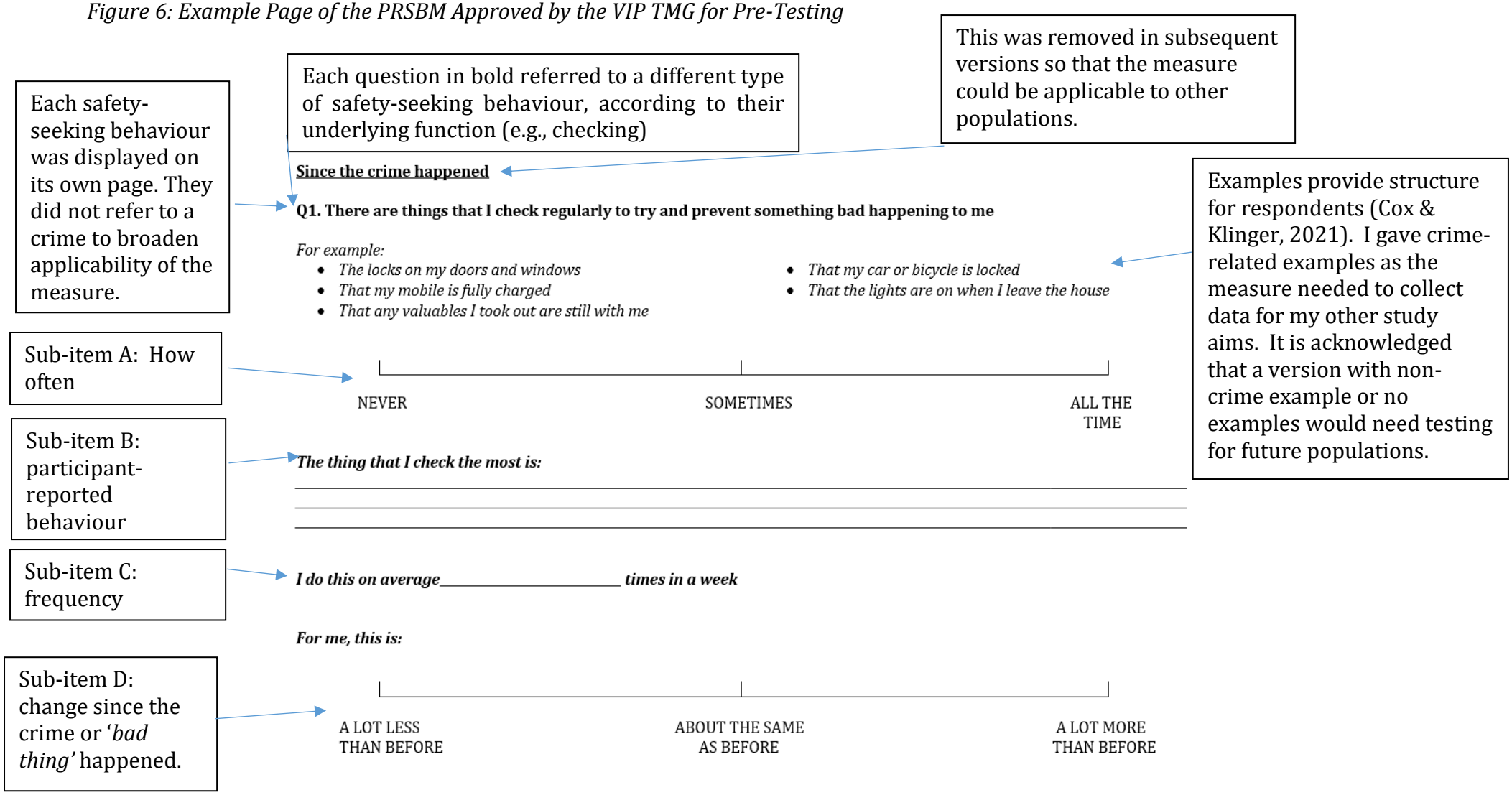


Figure 7: Summary Overview of Questions in the PRSBM

Q1. There are things that I check regularly to try and prevent something bad happening to me

1A. I do this (scale: 'never' to 'all the time')

1B. The thing that I check the most is_____ (qualitative response)

1C. I do this on average _____ times in a week

1D. For me, this is: ('a lot less than before' to 'a lot more than before')

Q2. I look for information or ask other people for their opinions to help me judge whether I am safe

2A. I do this (scale: 'never' to 'all the time')

2B. The thing that I do the most is_____ (qualitative response)

2C. I do this on average _____ times in a week

2D. For me, this is: ('a lot less than before' to 'a lot more than before')

Q3. I go over in my head how I can prevent a similar situation from happening again

3A. I do this (scale: 'never' to 'all the time')

3B. The thing that I go over in my head the most is_____ (qualitative response)

3C. I do this on average _____ times in a week

3D. For me, this is: ('a lot less than before' to 'a lot more than before')

Q4. There are certain situations, places, people, or thoughts that I avoid

4A. I do this (scale: 'never' to 'all the time')

4B. The thing that I avoid the most is_____ (qualitative response)

4C. I do this on average _____ times in a week

4D. For me, this is: ('a lot less than before' to 'a lot more than before')

Q5. If I suddenly think about something bad happening to me, there are little things that I think, say, or do to help me feel better again

5A. I do this (scale: 'never' to 'all the time')

5B. The thing that I do the most is_____ (qualitative response)

5C. I do this on average _____ times in a week

5D. For me, this is: ('a lot less than before' to 'a lot more than before')

Q6. I am alert for people or situations that could be a threat to me

6A. I do this (scale: 'never' to 'all the time')

6B. The thing that I am alert for the most is_____ (qualitative response)

6C. I do this on average _____ times in a week

6D. For me, this is: ('a lot less than before' to 'a lot more than before')

Q7. There are things that I do in a different way

7A. I do this (scale: 'never' to 'all the time')

7B. The thing that I do differently the most is_____ (qualitative response)
7C. I do this on average _____ times in a week
7D. For me, this is: ('a lot less than before' to 'a lot more than before')

Q8. If you have any other examples
8A. I do this (scale: 'never' to 'all the time')
8B. The thing that I do the most is_____ (qualitative response)
8C. I do this on average _____ times in a week
8D. For me, this is: ('a lot less than before' to 'a lot more than before')

Chapter 16: Pre-Testing

16.1 Sample Characteristics

A sample of *N* = 31 initially distressed older crime victims pre-tested the PRSBM. The age range was 65 to 89 (mean = 73.6, SD = 6.75). Participants were reasonably balanced across genders and re-screening outcomes on the GAD-2 and PHQ-2. Just under two thirds were White British, whilst just over one third were from a minority ethnicity. The crimes experienced were predominantly theft-related, but there was also a small number of violent or interpersonal crimes (e.g., harassment, assault). The sample characteristics are summarised in Table 8.

Table 8: Sample Characteristics of Participants Who Pre-Tested the PRSBM (N= 31)

Age	Range = 65-89, mean age = 73.6, SD = 6.75
Gender	
Female Male	15 (48%) 16 (52%)
Ethnicity	
White British Minority Ethnicity	20 (65%) 11 (35%)
Crime type	
Theft Burglary Criminal damage Assault Distraction burglary Harassment Robbery	13 (42%) 9 (29%) 5 (16%) 1 (3%) 1 (3%) 1 (3%) 1 (3%)
Rescreening on GAD-2/PHQ-2 at 3 Month's Post-Crime	
Positive Negative	18 (58%) 13 (42%)

16.2 Results from Cognitive Interviewing: Participant Feedback and Observations

I now summarise the feedback received from participants using the cognitive interviewing technique recommended by Willis (1999) (described in Chapter 14) and the changes made accordingly. A summary of when each change was implemented is presented in Table 9.

16.2.1 Visual

Some participants wore reading glasses when completing the PRSBM. All confirmed that they could clearly read the text, either with or without glasses.

16.2.2 Comprehensibility

The questions generally worked well, with only minor adjustments to phrasing and grammar recommended. Participants appeared to understand that the measure was enquiring about anxiety-driven behaviours, even if they did not think it applied to them. For checking, reassurance-seeking, rumination, avoidance, rituals, and hypervigilance, participants consistently provided qualitative examples which corresponded with that function. For example, for checking, participants provided a range of behaviours (e.g., checking locks, checking their mobile phone was still with them) but all met the criteria of 'checking behaviours'. The main exceptions were questions 7 and 8, which are further discussed below.

For the 'how often' and 'change' rating scales, participants appeared to find the use of visual analogue scales confusing. They consistently circled one end of the measure rather than placing an *X* anywhere on the line. This continued even when efforts were made to clarify the instructions. I then tried using anchored visual analogue scales, which

are fixed lines with added intermediate marks to help participants locate their place on the scale (Food and Drug Administration, 2009). This did not seem to help, nor did adding a coversheet with an example of a completed visual analogue scale mid-line. I then tried using Likert scales, which are rating scales with an ordered set of terms along the line, which asks participants to select the one most applicable to them (FDA, 2009). I consulted a statistician who advised that Likert-scales of seven points or more can be treated as continuous data, and are statistically comparable to using visual analogue scales (Robitzsch, 2020). This appeared more intuitive, as participants were consistently able to complete the PRSBM using Likert scales.

The frequency sub-item (*'I do this on average ___ times a week'*) was also problematic. It became clear that frequency alone was not a meaningful indicator of how intrusive a behaviour was. For example, participants commonly reported checking their front door was locked once a day when leaving the house, but some did this fleetingly whilst others spent much longer. The question was therefore amended to *'I do this on average ___ times a week. Each time, I spend an average of ___ doing this'* to measure overall time spent. This worked for checking behaviours, but participants fed-back that they struggled to place a figure on how long they spent avoiding something. Some avoided only at certain moments (e.g., when the phone rang), estimating this as a few seconds. Others were in a constant state of avoidance (e.g., not leaving the house), estimating this as '24 hours, 7 days a week'. The vast range of potential values supplied would make it difficult to draw meaningful comparisons across participants. It was also unclear whether the time spent on the behaviour is important or whether it is the act itself, however brief (e.g., not answering the phone). The 'how often' and 'change' rating scales were comparatively more adaptable to the range of behaviours qualitatively described by participants. I therefore decided that the time/frequency subitem required further

development in future studies, and is possibly better suited to measuring change within-participants. As the focus of my study is between-participants, I removed this sub-item from my analysis plan.

Taken together, the 'how often' and 'change' rating scales worked well within the context of the measure when presented as Likert scales. The frequency/time sub-item did not work well, even when amendments were made, so further development is needed before this item can be meaningfully analysed.

16.2.3 Observations and Hesitancy

The PRSBM was initially tested as a self-completion measure. Participants hesitated on questions they did not consider relevant to them as they were uncertain how to respond to sub-items. I then added a screening question '*Is this something that you do?*' (yes/no). If participant selected 'no', they were then instructed to move on to the next page. This appeared more intuitive to participants and sped up completion time. However, participants often looked to me for confirmation that they could skip the question. I then tested the PRSBM as a researcher-assisted measure, in which I sat next to the participant so that we could both see the text. I read questions aloud and if they said it did not apply, I turned the page over and read the next question. If participants indicated that this was relevant to them, I read the sub-items aloud. I wrote their qualitative behaviours verbatim so they were exactly as they described and I asked them to point to the place on the scale they considered most accurate. Participants seemed to prefer this method and completion time was quicker.

16.2.4 Response Burden and Acceptability

Self-completion time ranged from 10 – 20 minutes, with an average time of 13.6 minutes. Completion was notably quicker when the screening question was introduced, and when the measure was researcher-assisted instead of self-completed. When asked, respondents reported that they did not find the measure too burdensome, although this may have been socially desirable responding. No participants expressed distress when completing the measure and many seemed to resonate with it (*e.g., 'Oh yes, I do that a lot'*).

16.2.5 Face Validity

When asked, all participants except one recognised the PRSBM was interested in anxiety-driven behaviours after the crime. One participant thought it was an assessment of how careful they were with their belongings.

16.2.6 Internal Mapping

Internal mapping refers to whether the answers participants want to give fit in with the options available (Willis, 1999). This appeared to improve with the introduction of the screening question, as participants did not have to answer questions for behaviours which did not apply. Overall, the answers provided by participants fitted well for the first six safety-seeking behaviours: checking, reassurance-seeking, rumination, avoidance, rituals, and hypervigilance.

Answers did not appear to fit in as well with the seventh safety-seeking behaviour (*Doing things in a different way).* Some reported single incidents (e.g., installing burglar alarms) which were difficult to meaningfully rate in terms of how often this was, and

some repeated behaviours they had already mentioned. The final question (*Any other examples*) was often left blank, with participants stating that they did not have anything further to add. This suggested that the first six safety-seeing behaviours were sufficiently comprehensive and the final two questions (*Doing things in a different way, Any other examples*) were not adding anything to the PRSBM. However, I was interested to see whether there were any exceptions to this in the larger sample, so I retained the questions at this point.

16.3 Version History of the PRSBM

Researchers are encouraged to make the development history of their PROM available and publicly accessible (FDA, 2009). A summary of amendments made during pre-testing is presented in Table 9. There were four major amendments to the PRSBM before a version was decided on for the larger sample.

Table 9: Summary of Changes in Each Version of the PRSBM

Version	**(n)**	**Changes Made**
V1	8	First version of the PRSBM.
V2	5	1) A screening sub-item was added: "*is this something that you do?'* (yes/no) '*if no, go to next page'.* This was added so that respondents did not have to complete sub-items if the main item did not apply to them. This meant the measure was quicker to complete if an item was not relevant. 2) Layout change The layout was changed to include the screening sub-item. The sub-items were also re-ordered based on participant recommendation, which they thought would be clearer. 3) The statement '*since the crime happened*' was removed. This was removed to broaden the PRSBM's applicability to other populations in future studies. 4) Visual Analogue Scale (VAS) changed to anchored VAS This was changed because respondents appeared to find the VAS confusing; they consistently marked one end of the line instead of the middle. An anchored VAS with intermediate marks along the line was tested instead.
V2.1		5) Cover sheet with an example of a completed anchored VAS This was added as participants still appeared to find completing the anchored VAS confusing even with the addition of interim lines.

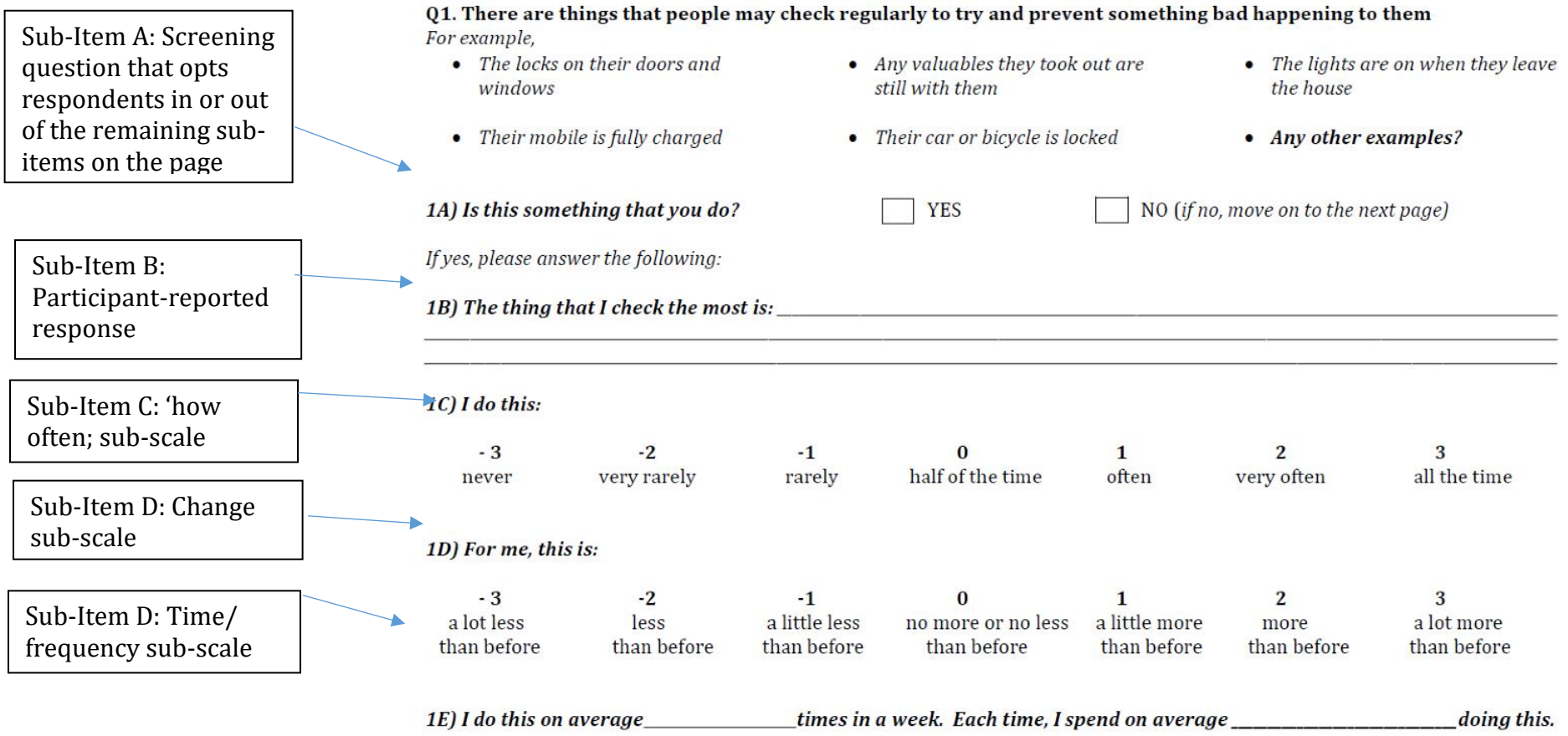
V3	9	6) Anchored VAS changed to 7-point Likert scale. This was changed as participants still appeared to the find the rating scales confusing. A 7-point Likert scale from -3 to +3 was chosen, as it was advised that this could be treated as continuous (Robitzsch, 2020). Words were added underneath each number to clarify what the numbers represented (e.g., '*A little more than before', 'A lot more than before').* The cover sheet with the example anchored VAS scale was removed. 7) Example under Q3 *'planning what they would they say to the offender'* changed to '*planning how they would respond to the offender'.* This change was made on the recommendation of a participant. 8) Q3 '*I go over in my head how I can prevent a similar situation from happening again'* changed to '*I go over in my mind how I can prevent a similar situation from happening again'.* This change was made on the recommendation of a participant.
V3.1		9) Wording of questions changed from first person ('*There are things I check regularly')* to third person ('*There are things people check regularly').* This change was made after the introduction of the screening question ('*Is this something that you do?'*) as it made more grammatical sense. 10) Example '*Trying not to think about somebody breaking in'* changed to '*Thinking about somebody breaking in'.* This was changed on the recommendation of a respondent. As the question asks about avoidance, '*Trying not to think'* was considered a double negative. 11) Likert scale option '*Half of the time'* changed to '*Some of the time'* This was changed on the recommendation of a respondent as was considered to be less restrictive.

V4	9	12) The frequency item '*I do this on average___ times a week'* changed to '*I do this on average____ times a week. Each time, I spend an average of* _____ doing this'. This was added to give an overall measure of time spent on the behaviour instead of just frequency. 13) Change of layout The ordering of the questions was changed again based on respondent feedback. 14) Minor re-phrasing of questions to sound less formal This was recommended by a participant.

16.4 The Final Draft of the PRSBM

The revised PRSBM to be used in the larger sample was researcher-assisted, had screening questions so participants could opt out of non-relevant behaviours, and used Likert scales. This was working consistently for six behaviours (checking, reassurance-seeking, rumination, avoidance, rituals, hypervigilance), but there were some issues with the final two questions (*doing things in a different way, any other examples*). The time/frequency sub-items were problematic so were removed from the analysis plan, but the 'how often' and 'change' subscales were working well. An example page of the final PRSBM from pre-testing is presented in Figure 8 and the full version is in Appendix 8.

Figure 8: Screenshot of the Revised PRSBM Based on Feedback from Older Victims During Pre-Testing



Chapter 17: Results from the Larger Sample

17.1 Sample Characteristics

There were *N* = 100 older victims in the larger sample. They were similar in age to the pre-testing sample, ranging from 65 to 89 (mean = 73.45, SD = 6.49). Over two-thirds were female, whereas the pre-testing sample was more evenly balanced across genders. Almost two-thirds were white British and one third from minority ethnicities, which was similar to the pre-testing sample. Burglary and theft continued to be the most common crimes but this sample had slightly higher proportions of violent and fraudulent crimes. Three-quarters (75%) of this sample rescreened positive and one quarter (25%) rescreened negative, whereas the split was 58%/42% in the pre-testing sample. The sample characteristics are summarised in Table 11.

Table 10: Sample Characteristics of the Larger Sample of the PRSBM (N = 100)

Age	Range = 65-89 Mean = 73.45 SD = 6.49
Gender	
Female	68 (68%)
Male	32 (32%)
Ethnicity	
White British	62 (62%)
Minority Ethnicity	37 (37%)
Missing	1 (1%)
Crime type	
Theft	34 (34%)
Burglary	25 (25%)
Criminal damage	10 (10%)
Fraud / distraction burglary ('deceptive crimes')	12 (12%)
Assault	9 (9%)
Harassment	1 (1%)
Robbery / aggravated burglary ('violent theft')	8 (8%)
Rescreening on GAD-2/PHQ-2 at 3 Month's Post-Crime	
Positive	75%
Negative	25%

17.2 Overview of Behaviours

Checking was the most endorsed behaviour (n = 87, 87%) at three-month follow-up. Much of the sample also endorsed hypervigilance (n = 83, 83%), rumination (n = 73, 73%), avoidance (n = 67, 67%), rituals (n = 53, 53%) and 'other examples' (n = 50, 50%). The least common behaviour was reassurance seeking, although this was still endorsed by over a third (n = 34, 34%).

17.3 Qualitative Findings

A summary overview of codes and themes surrounding reported behaviours on the PRSBM is presented in Table 12.

17.3.1. Checking

Most checking behaviours related to household security, including locks on doors and windows, burglar alarms, or that lights and television are on '*to give the appearance of someone at home'*. One participant described routinely *'preparing the house to look like someone is still in',* which included laying mugs on the kitchen table. Checking behaviours were usually when leaving home or going to bed, but some reported checking on their return for signs of damage, that no one was hiding, or that their valuables were still there. A few older victims reported checking their cars were locked or that tyres had not been slashed. Other items older victims checked were mobile phones, purses, and keys. This was normally checking the items were still with them when out, but some reported checking their phones were fully charged when leaving the house in case of emergency. Finally, some reported checking the people around when leaving home, the identity of those calling them or at their door, or that no one was watching them enter their pin

number at an ATM. One older victim reported checking that the perpetrator who had assaulted her was not on the bus before getting on.

17.3.2. Reassurance-Seeking

Reassurance-seeking was normally from friends, relatives, or partners (e.g., '*I call my family and friends when I cannot find my purse'),* although one older victim reported having visited her GP three times. The purpose of reassurance-seeking appeared to be for comfort, advice, to ask whether their loved ones were safe, or see whether other people had had similar experiences. A few reported seeking reassurance from the internet, such as checking local crime reports, whilst another reported having a panic alarm next to her bed. Two examples were more extreme. One older victim reported spending six hours daily watching home-CCTV and logging unusual activity. Another reported that her children had installed webcams inside her home so that they could remotely monitor that she was safe.

17.3.3. Rumination

Rumination was broadly divided into thinking over what they should have done differently or what they could do differently in the future. Older victims described making risk assessments, imagining how they would respond in different scenarios, or giving themselves regular mental reminders (e.g., *'Be careful when opening emails', 'Don't wear valuables outside the house'*). One older victim reported that keeping the crime at front of mind helped them stay alert, whilst others found it helped with emotional regulation, including self-reassurance ('*I think when I'm out 'I've done my best to keep safe'')* and self-restraint ('*Don't escalate confrontation even when I'm right').*

17.3.4. Avoidance

Most avoidance behaviours were avoiding going out alone, going out after dark, or going out altogether (e.g., '*I haven't been out for 3 or 4 weeks')*. Whilst some avoided leaving the house, others reported the reverse and avoided staying home '*in case somebody came'.* Avoidance of strangers was common, including avoiding answering the front door or telephone, avoiding crowds, queues, or certain groups of people. Others avoided places such as shops, parks, quiet streets, or areas perceived as high crime (e.g., '*central London*'). Several reported avoiding using ATMs, online banking, or carrying cash. Taken together, these behaviours appeared restrictive and either negatively impacted on things they previously enjoyed (e.g., '*going on holiday'*) or their independence ('*all places I used to go by myself*'; *'I don't use cash machines. I have to go into the bank which is further away because it has to be one with a level floor* [for wheelchair access]'.

17.3.5. Rituals

The most common rituals were religious actions including prayer, talking to God, going to church, or putting on religious music. Gestures for good luck (e.g., crossing fingers, knocking on wood) or to ward off bad luck (e.g., wearing crystals) were also reported. Others adopted distraction techniques, such as thinking about other things, thinking back to happier times, or having a cup of tea or a cigarette. Cognitive rituals in the form of repeating messages to themselves (e.g., *'I tell myself 'I'm being ridiculous''*) were also reported.

17.3.6. Hypervigilance

These behaviours mostly centred around looking out for suspicious activity (e.g., '*Looking out the window', 'looking around when walking down the street'*). A few reported logging their observations (e.g., '*I carry a recorder and take photographs'*) or reporting them in a neighbourhood WhatsApp group. Some reported specific places (e.g., '*the tube', 'the pub', 'central London')* or situations (*e.g., 'when using my pin', 'when stopping at red lights')* they were most on guard. For some, hypervigilance was specifically at night and included intentionally staying awake, sleeping with protective objects (e.g., *'a walking stick'*) by their bed, or getting up to check noises. Other behaviours included holding onto bags more tightly or confirming the identity of people knocking on their door, calling their phone, or sending them emails (e.g., *'I ask people to knock a pre-specified amount of times so I know it's them knocking on the door').*

17.3.7 Doing Things Differently / Any Other Examples

Consistent with pre-testing, the questions "*There are things people may do in a different way to stop another bad thing from happening"* and "*If you have any further examples"* did not work as well. There were some new examples (e.g., '*hiding valuables around the house'*), but many were repeated from elsewhere (e.g., '*sleeping next to a weapon'*). This sample also reported single events which could not be as meaningfully rated on the scales, including installing burglar alarms, extra lighting, and buying a safe. One participant reported taking out life insurance and making funeral arrangements; although she reported doing this after the crime, she said this was also due to a bereavement. This supports the findings from pre-testing that safety-seeking behaviours

1-6 were effective in capturing the full range of different behaviours, whereas Q7 and Q8 were not adding anything additional to the PRSBM.

Table 11: Summary Overview of Codes and Themes in the PRSBM (N = 100)

Item	Themes	Codes	Example Quote (gender, age, crime)
Checking (*n* = 87, 85%)	Household security (Leaving home or going to bed)	Locks on doors / windows Burglar alarms Lights on Television / radio Making it look like someone is home That no one is watching	"Doors and windows are locked. I go out and then come back in and check again"- (F, 65, ABH) "Prepare the house to make it look like someone is in – lights on, wireless on, mugs out in the kitchen" – (F, 87, theft from person)
	Household security (returning home)	Windows / door not smashed No one hiding in the house That valuables are still there	"I come in and check that the door has not been smashed" (F, 77, burglary)
	Cars	Doors locked Valuables removed	"I check my tyres [have not been slashed]" – (M, 77, criminal damage)
	Bags / purses / keys	Items still on them when out Still in its hiding place	"Checking my purse is still there and talking to myself to confirm it's in place" – (F, 96, theft other)
	Mobile phone	Still with them when out Fully charged when leaving	"That I still have my phone and that it's kept in a better, safer place" – (M, 71, theft from person)
	Banks	Checking whose around Checking not being observed when typing in pin number	"Check if anyone is viewing me using my pin number" – (F, 69, theft other)
	People	That the perpetrator is not around Checking the identity of callers Not opening the doors to strangers	"I check whether the person who did this is on the bus or getting on" – (F, 66, ABH)
Reassurance seeking (*n* = 34, 33%)	Support from friends and family	For comfort To ask for advice To check they are safe That other people have had similar experience To ask whether they noticed anything suspicious	"I call relatives when I'm feeling afraid" – (F, 66, burglary) "I ask people with me 'did you notice that' or 'are they walking behind us' (F, 66, theft other)
	Professionals	GP Psychiatrist / crisis team	"I've been to my GP 3 times" (F, 68, robbery of personal property)
	Panic alarm	Next to bed	"I have a panic alarm next to my bed" – (F, 66, theft from motor vehicle)
	Internet / TV	Crime prevention advice To check local crime reports Watch CrimeWatch[9]	"Searching the internet for local news and crime prevention information" (F, 66, theft from person)

[9] CrimeWatch is a news organisation based in the UK that shares information about crime happening in local communities: https://www.crimewatch.co.uk/

		Check [neighbourhood]Safe website	
	Security and surveillance	Check home CCTV and log unusual activity Children monitor webcams in home	"Check the security camera on the TV screen and log timings of unusual events" – (M, 71, theft from motor vehicle) "My children monitor the webcams installed in my home" (F, 77, distraction burglary)
Rumination (*n* = 72, 73%)	Thinking about what they can do	Responding differently next time Risk-assessing different scenarios What more can be done to make sure I am safe? How can I learn from this? Extra security	"I'd call the police. I think about this whenever I leave the house, I'm always thinking 'when is the next break-in?" – (F, 76, distraction burglary)
	Thinking about what they should have done	How I could have prevented this What could I have done better If only I'd questioned this	"Thinking about how I could have prevented my blue badge from being stolen" – (M, 71, theft from motor vehicle)
	Reminders	Keep things in safe place Check things are locked away Check who is around at cash machines Be careful Do not talk to strangers Don't wear anything valuable Make sure your zip is done up Be careful about opening emails Sit on the seat at the bus stop so no one can stand behind you Don't trust people Don't carry large sums of money	"I have to check daily because criminality is a daily occurrence" (M, 68, burglary) "Sit with everyone coming towards me, don't sit with my back exposed, sit against something solid"(F, 66, ABH)
	Self-management	Self-reassurance Self-restraint Keeping self-alert	"Don't escalate confrontation, even if I am right" – (66, M, racially aggravated assault) "I think when I'm out 'I've done my best to keep safe'" (F, 76, burglary) "By thinking about it a lot, it makes sure I am more aware" (88, F, distraction burglary)
Avoidance *(n = 67, 65%)*	Going out	Going out Going out alone Going on holiday Going out after dark Staying in the house	"I don't go out. I've not been out for 3 or 4 weeks" (F, 81, theft) "Going out after dark or I get a taxi if I have to" (F, 73, robbery) "I try to avoid staying in the house as much as possible" (F, 72, aggravated burglary)
	Strangers	Answering the door Answering the phone Walking past certain groups of people Standing in a queue People begging Crowds	"I leave the queue if someone is standing behind me" (F, 69, theft)

	Places	Central London Communal areas The shops Using valuables in vulnerable areas Walking down quiet streets	"I avoid Hackney Downs, the River Lea, all places I used to go by myself" (F, 72, theft from motor vehicle) "I don't go to some people's houses in case they make a copy of my key" (F, 66, burglary)
	Money	Using ATMs Using online banking Carrying cash Carrying purse in backpack	"I don't use cash machines. I have to go into the bank which is further away because it has to be one with a level floor" (F, 71, robbery)
Rituals (*n* = 53, 52%)	Religious	Prayer Go to church Put on Christian music Look at Buddha ornament	"I pray when I come back to the flat and then I pray to say thank you" "Go to church (I feel calmer for going)"
	Distraction	Think of other things Go and talk to people Go have a cigarette Go make a cup of tea	"When I feel rage, I go distract myself" "I think of my wedding day"
	Lucky	Talisman Crystals Knocking on wood Crossing fingers	"Put on a black tourmaline bracelet"
	I say to myself	It could have been worse I hope nothing bad will happen to me This is ridiculous	"I say to myself 'it could have been worse'" "I say to myself 'I hope nothing bad will happen to me"
Hypervigilance (*n* = 81, 83%)	Looking out for suspicious activity	When walking down the street In the neighbourhood Looking over shoulder Look around to see if anyone is following Looking out the window Keeping an eye on people parked outside the house People behind me or sat next to me Communication between neighbours People loitering CCTV Logging suspicious activity Neighbourhood Watch WhatsApp group Hold bag tightly	"I look around to see if anyone is following me "I carry a recorder and take photographs"
	Specific places or situations of increased vigilance	Using cash machines / pin number Meeting my neighbour Opening the door Public transport Shops The pub Car locks on when stopping at red lights When out at night	"I'm more vigilant on the tube and in Smiths"
	Night-time	Staying awake at night Sleeping with a weapon Getting up in the night to check on noise Look in every room before bed	"I sleep with my walking stick next to me so I can defend myself"

	ID Checks	Checking caller ID Care when opening emails Block unknown numbers When opening the door	"I ask people to knock a pre-specified amount of times so I know it's them before I open the door"
Doing things in a different way/ Any other examples (n = 50, 50%)	One-off changes	Installing security camera Buying a personal alarm Buying a safe Extra lights Police sticker	"Put together life insurance and funeral plans (I started doing this after the crime, although a bereavement made it worse)"
	Doing things in a different way	Hiding valuables around the house Lock myself inside the house Not wearing valuables outside the house Sleeping with weapon by bed Wearing a crossover bag	"Carrying my bag close to my body, unlike before when I hung it over my shoulder" "I go into an imaginary world where I am a superhero and I imagine different scenarios and how I would overcome them"

17.4 Quantitative Results

17.4.1: Exploring the Psychometrics of the PRSBM

I explored the psychometrics using Unique Variable Analyses (UVA) to test whether any scales in the PRSBM substantially overlapped (Table 13). As the '*Any other examples*' question was optional, it had a high volume of non-responses, so was excluded from analysis. The UVA tested every possible pairing of scales for the other seven safety-seeking behaviours to identify which were highly correlated.

No correlations across safety-seeking behaviours were detected (e.g., change in checking, avoidance 'how often'). However, the 'how often'/'change' pairings within each safety-seeking behaviour were all found to be highly correlated, with substantial Weighted Topographical Overlap above the 0.25 threshold: doing things in a different way (0.666), avoidance (0.616), reassurance-seeking (0.605), rumination (0.489), hypervigilance (0.471), rituals (0.315), and checking (0.280). As these are positive correlations, it suggests that older victims who were scoring highly on the 'how often'

scale were also scoring highly on the 'change' scale. Together, the scales were jointly showing increases or decreases in behaviours attributed to the crime.

Table 12: Unique Variable Analysis

Items in Order of Most Correlated	**Scale Pairings with Weighted Topographical Overlap Above 0.25**	**Weighted Topographical Overlap**
Doing things in a different way	OFTEN-CHANGE	0.666
Avoidance	OFTEN-CHANGE	0.616
Reassurance-seeking	OFTEN-CHANGE	0.605
Rumination	OFTEN-CHANGE	0.489
Hypervigilance	OFTEN-CHANGE	0.471
Rituals	OFTEN-CHANGE	0.315
Checking	OFTEN-CHANGE	0.280

17.4.2 Safety -Seeking Behaviours on Continued Psychological Distress

I conducted logistic regression to test whether safety-seeking behaviours were associated with continued psychological distress in older victims. As both pre-testing and qualitative analyses suggested that '*Doing things in a different way'* and '*Any other examples'* were not collecting meaningful data, these were not included. My analyses focused on checking, reassurance seeking, rumination, avoidance, rituals, and hypervigilance using the 'how often' and 'change' scales.

17.4.2.1 Missing Data

As the final version of the PRSBM was researcher-assisted, the amount of data missing was minimal. The maximum amount of missing data at any point in the analyses was 3%, which was within the acceptable limit of 5% or below (Schafer, 1995). I therefore proceeded to analyses without imputing missing data.

17.4.2.2 Outliers

There were no outliers on the 'how often' scales. On the change scales, there was one for reassurance-seeking (Std. residual = -2.65), two for avoidance (Std. residual = 3.23), two for rituals (Std. residual = 3.40), and one for hypervigilance (Std. residual = 2.95). A visual inspection found that these were the same two participants. They had reported engaging in these behaviours a lot more than before the crime but had re-screened negative for psychological distress. Examination of their crime type and qualitative responses found that one had lost their purse and reported behaviours such as avoiding carrying cash. The other had been burgled and reported behaviours such as not going out as much as they used to. These were automatically removed by SPSS and I considered the implications in the discussion (Chapter 18).

17.4.2.3 Univariable Logistic Regression

I used univariable logistic regression to test whether behaviours were individually associated with continued psychological distress (Table 14). I tested each 'how often' and 'change' scale with the rescreening outcome in isolation (the unadjusted odds ratio; UOR) before adjusting each scale for gender (bivariable adjusted odd ratio; AOR), gender and age (multivariable AOR), and gender, age and crime type (fully adjusted OR).

Rumination and reassurance-seeking were not associated with continued psychological distress on either the 'how often' or 'change' scale. Rituals was not associated on the 'how often' scale but was associated on the 'change' scale. Checking, avoidance and hypervigilance were each associated with continued psychological distress on both the 'how often' and 'change' scales. This suggests that for every point increase on these scales, the odds of re-screening positive for psychological distress was increased. The 'change' scales had particularly high odds, which were almost 2.5 for

rituals, 2.0 for avoidance, 1.91 for hypervigilance, and 1.70 for checking. Adjusting for age, gender, and crime type found that these estimates remained broadly similar, suggesting the associations were unaltered. The main exceptions were avoidance ('how often') adjusted for gender, and rituals ('change') adjusted for age, gender, and crime type.

Table 13: Univariable Logistic Regression Testing for Associations Between Safety-Seeking Behaviours and Psychological Distress, Adjusted for Age, Gender, and Crime Type

	Unadjusted [a]		**Bivariable** [b]		**Multivariable** [c]		**Fully Adjusted** [d]	
How Often	**UOR (95% CI)**	***p***	**AOR (95% CI)**	***p***	**AOR (95% CI)**	***p***	**AOR (95% CI)**	***p***
Checking	1.34 (1.09-1.65)	.006**	1.33 (1.06-1.66)	.014*	1.29 (1.02-1.63)	.035*	1.36 (1.05-1.76)	.021*
Reassurance Seeking	1.19 (0.95-1.51)	.134	1.16 (1.8-12.68)	.269	1.16 (.91-14.97)	.221	1.24 (.95-1.62)	.114
Rumination	1.19 (0.98-1.44)	.084	1.24 (.99-1.53)	.052	1.22 (.98-1.52)	.071	1.26 (.98-1.61)	.069
Avoidance	1.26 (1.05- 1.51)	.014*	1.18 (.98-1.44)	.081	1.18 (.97-1.44)	.104	1.16 (.93-1.43)	.181
Rituals	1.14 (0.95-1.37)	.166	1.11 (.92-1.35)	.275	1.10 (.90-1.34)	.349	1.13 (.91-1.41)	.261
Hypervigilance	1.31 (1.07-1.59)	.008**	1.28 (1.04-1.57)	.020*	1.27 (1.02-1.57)	.032*	1.32 (1.03-1.68)	.027*
Change								
Checking	1.70 (1.18-2.46)	.004**	1.71 (1.16-2.53)	.007*	1.62 (1.08-2.44)	.020*	1.77 (1.14-2.75)	.011*
Reassurance Seeking	1.40 (0.83-2.35)	.202	1.39 (.82-2.37)	.221	1.34 (.78-2.29)	.285	1.53 (.82-2.85)	.180
Rumination	1.31 (0.92-1.86)	.130	1.44 (.98-2.12)	.063	1.38 (.93-2.05)	.108	1.38 (.91-2.11)	.133
Avoidance	2.0 (1.33-2.99)	<.001**	1.95 (1.28-2.99)	.002**	1.94 (1.27-2.97)	.002**	1.86 (1.19-2.92)	.007**
Rituals	2.43 (1.21-4.87)	.012*	2.24 (1.12-4.49)	.023*	2.09 (1.04-4.19)	.037*	1.99 (.94-4.19)	.071
Hypervigilance	1.91 (1.25-2.91)	.003**	1.88 (1.19-2.96)	.007**	1.78 (1.12-2.84)	.015*	1.93 (1.15-3.25)	.013*

[a] Separate univariable models for each safety-seeking behaviour using 'how often' and 'change' scales.
[b] Adjusted for gender
[c] Adjusted for gender and age
[d] Adjusted for gender, age and crime type
* Significant at $p < .05$
** Significant at $p < .01$
UOR = Unadjusted odds ratio
AOR = Adjusted odds ratio

17.4.2.4 Multivariable Logistic Regression

I carried forward the variables significant at p <.05 on the fully adjusted univariable logistic regression for further testing: checking (often, change), avoidance (change), and hypervigilance (often, change). I used multivariable logistic regression with backwards elimination at p <.05 to compare which behaviours were most strongly associated with re-screening positive for psychological distress (Table 15). As the Unique Variable Analysis had found that the 'how often'/ 'change' variables within each behaviour were highly correlated, I adopted a cautious approach and entered these into separate models in case of multicollinearity.

Of the 'how often' variables, backwards elimination removed both checking and hypervigilance. Of the 'change' variables, backwards elimination removed checking and hypervigilance, but retained avoidance. This suggested the variable most strongly associated with continued psychological distress was an increased change in avoidance.

Table 14: Multivariable Logistic Regression Using Backwards Elimination Set to p < .05

	Odds Ratio	**95% CI**	***p***
Multivariable 'How Often'			
Checking	1.24	.99- 1.55	.062
Hypervigilance	1.22	.98- 1.51	.072
Multivariable 'Change'			
Checking	1.20	.78- 1.86	.405
Avoidance	1.81	1.18- 2.78	.007**
Hypervigilance	1.55	.98-2.46	.063
*Significant at p <.01			

17.5 Summary

Checking (often/change), avoidance (change), and hypervigilance (often/change) were all individually associated with re-screening positive for psychological distress after adjusting for age, gender and crime type. When compared against each other, avoidance (change) was the most strongly associated with re-screening positive for psychological distress.

Chapter 18: Discussion

I aimed to develop the first patient-reported measure of safety-seeking behaviours (PRSBM) to collect mixed-methods data in older victims. The PRSBM was refined through internal review, pre-testing, qualitative, and quantitative analysis. Older victims reported many behaviours but an increased change in avoidance was most strongly associated with continued psychological distress.

18.1 Qualitative Overview on the PRSBM

Reported behaviours on the PRSBM varied, but the overall finding was that they conceptually corresponded with the crime. As much of my sample had experienced property-related crimes, there were common themes, such as lock checking. Yet even within similar reports there were subtle differences reflecting their specific experiences. For example, '*Checking the car*' meant the locks for one participant and that the tyres '*had not been slashed*' for another. The PRSBM therefore appeared able to capture both nuances and commonalities in behaviours.

My findings support that safety-seeking behaviours reflect individuals' core concerns (Goetz et al., 2016; Gústavsson et al., 2021) and build on my qualitative study's findings on personal perspective. They also emphasise that idiographic components to measurement are important, calling into question the validity of previous measures which use standardised items set by researchers. Despite the breadth of responses, reports on the PRSBM were still consistently within the theme of the question (i.e., checking behaviours were reported for the checking question). This reinforces that safety-seeking behaviours are about their underlying function rather than their presentation (Hoffman & Chu, 2019), and that my measure could detect this.

Pre-testing found that older victims understood that they were being asked about anxiety-driven behaviours, and the compatibility of their responses indicates the questions were intuitive. The exceptions were '*Doing things differently'* and '*Any other examples',* which did not produce any further meaningful data. This suggests these items should be removed from the PRSBM, whilst the other six (checking, reassurance-seeking, rumination, avoidance, rituals, hypervigilance) should be retained. A six-item version of the PRSBM appears to have good content validity, which is considered the most important PROM psychometric property (FDA, 2009).

18.2 Quantitative Overview on the PRSBM

The majority of older victims endorsed five of the behaviours (checking, rumination, avoidance, rituals, hypervigilance), supporting that safety-seeking may be a constellation of behaviours rather than a single action (Borsboom et al., 2021). Reassurance-seeking was the least common, but was still endorsed by over a third. High rates of protective behaviours have previously been identified (Qin & Yang, 2018) but it was unclear whether this was specific to older victims or older people more generally. As my study is cross-sectional, I also cannot be certain these behaviours were not pre-existing, but it is a strength that the PRSBM at least asked whether the behaviours were a change. The validity of this is supported by finding that the change scales were most strongly associated with psychological distress. The 'change'/'often' scale pairings were also highly correlated with each other - suggesting large behaviour increases had occurred - as pre-existing behaviours would have been expected to score highly on 'how often' but not on 'change'. However, reporting biases are possible as older victims were aware they were being assessed for crime-related psychological distress and may have been primed to attribute their behaviours to this. Nonetheless, my initial findings are promising.

18.3 Safety-Seeking Behaviours in Older Crime Victims

18.3.1 Avoidance

Avoidance was the behaviour most strongly associated with psychological distress after adjusting for confounding. This adds to the evidence on avoidance in crime victims, which has previously focused on PTSD in working-age victims (Dunmore, Clark & Ehlers, 1999; Dunmore, Clark & Ehlers, 2001; Blakey et al., 2020). The qualitative responses suggest that avoidant behaviours in older victims may be highly restrictive. Avoiding leaving the house entirely was common, supporting studies in my systematic review reporting social isolation as a risk factor for psychological distress in older victims (Kraus, 1986; Reisig et al., 2017). As older crime victims have also been found to be at increased risk of nursing home placement (Lach et al., 2006), loss of independence through post-crime avoidance may be a mechanism of this.

Avoidance is a central maintenance factor for anxiety and depression (Moorey, 2010; Sharpe et al., 2022; Thwaites & Freeston, 2005) and a necessary (though not sufficient) criterion for PTSD diagnosis (Criterion C) (DSM-V-TR; APA, 2022). Crucially, avoidance must be attributed to the index trauma to qualify (DSM-V-TR; 2022), so finding that avoidance 'change' was strongly associated, but avoidance 'often' was not, aligns with this. Whilst the mental health impact of avoidance is well-established, the reason that finding this is important is because it suggests the PRSBM successfully measured the concept it was intended to, supporting its construct validity. The next step would be to replicate this in other samples.

The two outliers on avoidance change should be considered, however, as they had scored highly but rescreened negative. A strength of the PRSBM was that qualitative data was also available, which found that one reported avoiding carrying cash after having

their purse stolen, and the other did not leave the house after being burgled. It may be that avoidance promoted recovery and their symptoms remitted, suggesting this is healthy coping (Thwaites & Freeston, 2005). Alternatively, their symptoms may have ceased artificially because the behaviour shielded them from anxiety increases (Helbig-Lang & Petermann, 2010). For example, the burglary victim may have felt comforted by staying at home so he could guard it. He may therefore have accurately reported not feeling distressed, but symptoms may have presented if he did have to leave. A more comprehensive assessment of distress may have detected this. Given that avoidance has consistently been found to reinforce psychological sequalae (Akbari et al., 2022), it seems unlikely that this behaviour would be genuinely helpful longer-term.

18.3.2. Checking

Checking behaviours were consistent with those described in cognitive-behavioural theory, but it was unclear whether they were dysfunctional or not from the qualitative data alone. Checking cannot be identified as a safety-seeking behaviour from its topology; it is whether it impacts on functioning or quality of life which is relevant (Thwaites & Freeston, 2005). Pre-testing found older victims can estimate frequency and duration of checking, so further examination of this would have been useful, but it was not feasible in this study as it was not meaningful for the other behaviours on the PRSBM. Further development of this item, or using it as tool for monitoring within-person change, may be worthwhile (Ashworth et al., 2019).

Checking behaviours on the PRSBM appear to have been maladaptive as they were individually associated with psychological distress after adjusting for confounding. However, the associations became weaker when compared with avoidance. This may be because checking is considered a more subtle form of avoidance (Sharpe et al., 2022). It

may make anxiety tolerable, so the individual does not engage in outright avoidance and therefore has opportunities for threat exposure and belief disconfirmation (Rachman et al., 2008). For example, excessive lock checking may be unhelpful for distress in older victims when considered in isolation, but if it makes the difference between them leaving the house or not, then the overall impact may be less pronounced. Targeting outright avoidance may therefore be more important.

18.3.3 Hypervigilance

Hypervigilance was similarly individually associated with psychological distress but weaker when compared with avoidance. Some older victims combined hypervigilance with avoidance, such as the participant who spent all day monitoring home CCTV. Others were hypervigilant in specific places, like the bank or public transport, suggesting it otherwise helped them to maintain functioning. Studies have previously found that some hypervigilant individuals are highly avoidant whilst others are low in avoidance (Cisler & Koster, 2010; Kimble & Hyatt, 2019; Lindstrom et al., 2011). Several older victims reported intentionally staying awake at night and one reported sleeping next to a weapon, suggesting they did not feel safe in their own homes. Crimes like burglary may be especially distressing in older people as it is an invasion of somewhere that should feel safe and comforting (Delisi et al., 2014). The absence of a safe place may mean they have minimal relief from their symptoms (Golovchanova et al., 2023).

Hypervigilance is common after stressful events and not necessarily associated with negative symptoms (Kimble et al., 2013). It is a normal survival response for threats to attract attention so that protective action is elicited (Norris, 2021). However, problems arise when risk perception is exaggerated, as ambiguous information may be perceived as unsafe, diverting attention away from positive stimuli, and leading to overestimation

of threat (Gollan et al., 2016; Norris et al., 2011). Adverse experiences like crime may reinforce this if they are negatively interpreted by victims to mean that the world is dangerous or that they are vulnerable (Ehlers & Clark, 2000). Avoidance is a maladaptive coping response to these interpretations, which further motivates hypervigilance, suggesting the two are mutually reinforcing (Ehlers & Clark, 2000; Kimble & Hyatt, 2019; Van Bockstaele et al., 2014). This may accumulate throughout the lifetime as negative attributions were recently found to mediate the relationship between life-trauma history and subsequent PTSD after new trauma exposure (Webb et al., 2023). This supports my qualitative PhD study on the importance of life experiences on appraisals and coping. Taken together, hypervigilance combined with avoidance appears to be an important target for therapy.

18.3.4 Rituals

Finding that rituals are commonly reported by older victims is consistent with my qualitative study (Satchell et al., 2023) but otherwise new to the literature. The behaviours described on the PRSBM included religious practices (e.g., praying), non-religious actions like superstition (e.g., knocking on wood), and habits (e.g., smoking). Such behaviours might be expected to be pre-existing so finding no association with psychological distress on the 'how often' scale supports this. Although the often/change scales were highly correlated, they were closer to the threshold than many other behaviours, so there may have been differences which were not detected by my analyses.

Rituals change had higher odds of continued distress than any other behaviour individually, including avoidance. Yet the confidence intervals were much wider and the association was above p <.05 when adjusted for crime, so it was not eligible for comparison in the multivariable analysis, even though it was only just above threshold (p

= .071). This approach to logistic regression has been criticised, as variable selection is influenced by chance (Stoltzfus, 2011). However, proponents consider it highly informative for hypothesis testing, provided it is interpreted in context, which is why it is widely-used in clinical practice (Stoltzfus, 2011). It was also important to adhere to my *a-priori* statistical analysis plan to ensure transparency and reduce bias (von Elm et al., 2007). Replicating this in a larger sample of older victims may clarify the relationship between changing rituals and continued psychological distress, and would be worthwhile given its potentially large impact.

18.3.5 Reassurance-Seeking and Rumination

Neither reassurance-seeking nor rumination were individually associated with continued psychological distress on either scale. This may reflect healthy coping (Hoffman & Chu, 2019; Thwaites & Freeston, 2005), which would suggest they should be removed from the PRSBM. However, this contradicts the many studies reporting associations between these behaviours and anxious and depressive disorders (e.g., Brooks et al., 2017; Ehlers & Clark, 2000; Halldorsson & Salkovskis, 2023; Manrique-Millones et al., 2023; Moorey, 2010; Sharpe et al., 2022; Smith et al., 2022). Genuine associations may have therefore been missed. There may have been inadequate power, especially as reassurance-seeking was the least endorsed. Alternatively, these questions may need further development, although as the qualitative responses were compatible there appears to have been good content validity. Further testing is recommended to clarify this.

18.3.6 Doing Things Differently and Any Other Examples

Although '*Doing things differently*' was recommended by a PPI member, it may not have generated meaningful data because it has not been rigorously operationalised in the safety-seeking literature. Similarly, '*Any other examples*' was included to capture unanticipated responses (Neuert et al., 2021), but this did not contribute much new information. This suggests that the PRSBM is sufficiently comprehensive without these questions. Removing them may improve my measure by reducing response burden.

18.4 Strengths and Limitations

18.4.1 The PRSBM

The final version of the PRSBM is in Appendix 8. It is a researcher-assisted tool, covering six types of safety-seeking behaviours: checking, reassurance-seeking, rumination, avoidance, rituals, and hypervigilance. Respondents are asked whether each apply and, if so, to: qualitatively describe their behaviour, rate how often they do it, and how much of change it is since the crime.

I explored and refined the PRSBM using mixed-methods, the recommended first step for evaluating PROMs (Cappelleri et al., 2014; Hawkins et al., 2018). The six-behaviour version was found to be comprehensive, comprehensible, acceptable, person-centred, and could be used consistently with older victims when supported. It is the first measure to consider individual variation in safety-seeking behaviours and to ask whether the behaviour is a change. This enabled collection of person-centred data which could also be compared across participants. Using general wording (e.g., '*a bad thing*'), broadens its applicability to other adverse event populations. All six behaviours were found to have good content validity, which is considered the most important PROM

psychometric property (FDA, 2009). Avoidance also had good construct validity. The PRSBM has the potential to help clinicians identify the main psychopathology that could be addressed in therapy. It could also be used by researchers to accurately measure and compare safety behaviours for different conditions.

The PRSBM underwent internal review with the VIP Trial Management Group and PPI members, however, its design could have been further strengthened by conducting a Delphi study. The limitations of the PRSBM otherwise reflect wider challenges with evaluating PROMs because there are so few sources of external validation (Lyon et al., 2017; Sales et al., 2018). There is no gold standard safety-seeking measure and behaviours are subjectively reported so convergent and discriminate validity could not be assessed. I considered whether behaviours recorded on the PRSBM could alternatively be compared with therapist notes in older victims randomised to the VIP intervention. This was not feasible as my role on the VIP Trial required me to be blinded to allocation, although this could be assessed in further research. I also considered collecting comparative samples of non-victimised older adults, but this would have been meaningless as it would have been asking them to score changes since an arbitrary point three months earlier.

Test-retest and inter-rater reliability are not considered suitable for PROM evaluation because perspective is changeable (Reeves et al., 2018). However, having other researchers try the PRSBM may have clarified its wider useability. I considered whether I could assess internal consistency, but there was no *a-priori* reason to suggest that older victims who engage in one safety-seeking behaviour (e.g., checking) necessarily engage in another (e.g., avoidance). As the Unique Variable Analysis found that correlations were within behaviours (e.g., avoidance often/change) rather than across behaviours (e.g., avoidance change, checking change), it suggests there is not a simple

relationship. Further research is therefore needed to inform whether this would be meaningful.

The high correlations on the often/change scales may be viewed as item redundancy, which is usually considered undesirable as it can introduce bias (Christensen et al., 2023). However, I have outlined theoretical reasons to suggest that the two scales may behave differently to each other if behaviours are pre-existing. The high overlap therefore supports the PRSBM's validity in detecting behaviours attributed to the crime, which adds to its potential utility in clinical treatment.

18.4.2 The Overall Study

My findings contribute evidence on safety-seeking behaviours in older victims and the concept of safety-seeking behaviours more broadly. The PRSBM may be a useful tool for researchers and clinicians, and the development process adds knowledge on approaching PROM evaluation (Lyon et al., 2017; Regnault et al., 2018; Ashworth et al., 2019). Using mixed-methods enabled safety-seeking behaviours to be assessed from multiple perspectives (Johnson et al., 2007). The qualitative data also helped clarify the quantitative findings in this study and expanded my findings on individual perspective in my earlier qualitative study.

Embedding my study within the VIP Trial enabled recruitment of two samples of older victims at a defined timepoint (three months post-crime). However, as discussed in my earlier qualitative study, its eligibility criteria excluded subgroups of older victims such as those living outside of London, who do not speak English, or of sexual crimes. Including only police-reported crime may have overrepresented property crimes, which are often reported for insurance claims (Xie & Baumer, 2019), and underrepresented older victims from ethnic minorities or with complex care needs, who are less likely to

report (Jones & Elliott, 2018; McCart et al., 2010). As such my findings are unlikely to be representative of all older victims.

Using a cross-sectional design meant that causal relationships between safety-seeking behaviours and psychological distress could not be tested, nor the direction of the association. It was not possible to assess older victims before the crime had happened as they were identified through crime reports. As behaviours were self-reported, it was also not possible to verify whether they really were a change since the crime and recall biases are possible. Whilst collecting PRSBM data immediately after the crime (Step 1) may have alternatively enabled testing of predictors of continued distress at Step 2, this was not feasible due to data protection regulations. It would not have been practical nor ethical to have instructed the police to use a measure that had not yet been pre-tested. As the demands of the VIP Trial necessitated that the PRSBM was moved from Step 2 to baseline mid-way through data collection, there was a higher proportion of rescreen positive older victims in my larger sample than my pre-testing sample. This was considered preferable to reducing my sample size, but it may have introduced bias, so a replication study addressing this limitation is needed (APA, 2020).

Using the GAD-2 and PHQ-2 was a strength, as my systematic review had identified a lack of standardised measures in previous research. Although they are not diagnostic, they are strongly correlated with the GAD-7 and PHQ-9, which closely correspond with diagnostic criteria, so they are considered robust indicators of distress (Spitzer et al., 2006). Combing GAD-2/PHQ-2 scores into binary data (rescreen positive/negative) maintained consistency with the VIP Trial and has been recommended for clinical practice and non-academic audiences (Farrington & Loeber, 2000). However, it does not show whether the association was with anxiety, depression, or both. Using continuous data instead may have provided more detail on the relationship (Lazic, 2008). Additional

screening tools for PTSD (e.g., CAPS-5; Weathers et al., 2018) or the Traumatic Events Scale (Sundin & Horowitz, 2002) may have been informative, but there was a risk of response burden in participants, who were also completing other assessments for the VIP Trial. As discussed in Chapter 1, it is also unclear whether community crimes qualify as a traumatic event under PTSD diagnostic criteria (e.g., DSM-V-TR, ICD-11; APA, 2022; WHO, 2021).

It was a strength that I included age, gender, and crime type as possible confounders. As the range of recorded crime types was extensive (Appendix 2), it was necessary to organise these into smaller categories, which was done subjectively and may have introduced bias. Adjusting for additional factors, such as previous depression and anxiety, whether participants lived alone, or whether the perpetrator was arrested may have provided further insight into confounding. However, testing too many variables without an *a-priori* hypothesis is considered bad practice as it increases the risk of false positive findings ('data dredging'; Andrade, 2021). I therefore focused my analysis on confounding to a few key variables. As an investigation into predictors of continued distress in older victims is understudy elsewhere (Serfaty et al., in prep), this may help identify which variables should be prioritised in future research.

Despite these limitations, my study is the first to enquire about safety-seeking behaviours in older victims so provides the strongest available evidence to date.

18.5 Future Research

Further research into safety-seeking behaviours in older victims is important. Firstly, a study in a representative sample of older victims is needed to assess the generalisability of my findings. Secondly, a cohort study would be helpful to clarify the relationship between crime, safety-seeking behaviours, and mental health (Barrett & Noble, 2019).

This may involve assessing a large sample of older adults, following up to see who has since become a victim, and then re-assessing. Whilst this requires substantial resources, this could be overcome by embedding this as a sub-study within broader longitudinal research on ageing (e.g., Lachs et al., 2005; Muhammad et al., 2021a).

As the PRSBM appears promising as a clinical and research tool, further development is recommended in both older victims and other adverse event populations. Firstly, other researchers should pre-test the measure so that its instructions can be refined, until it is simple for a range of people to use without prior training. Secondly, the PRSBM in this study included crime-related prompts to give participants structure (Cox & Klinger, 2021) but testing without these or with prompts applicable to a broader range of responses would be helpful. Thirdly, further collection of quantitative and qualitative data is important for evaluation (Hawkins et al., 2018). This includes in: older victims of community crime who did not feature in my sample (e.g., sexual crimes, unreported crime), other older victim samples such as elder abuse, domestic violence, and younger victims, and samples who have experienced other stressful events such as injury, bereavement, divorce, natural disasters, and motor vehicle accidents. If the PRSBM was also found to be acceptable, comprehensible, and useable across these different groups, it would strengthen its applicability considerably.

Thirdly, although psychometric evaluation is challenging for PROMs, further exploration may be insightful. This includes assessing whether the findings of the Unique Variable analysis and logistic regression are replicated in other samples. Testing whether there are particular patterns of safety-seeking behaviours that people engage in may also inform whether assessing internal consistency of the PRSBM is suitable. Investigating whether engaging in multiple safety-seeking behaviours is more strongly associated with distress would also inform whether a summative score on the PRSBM is appropriate.

Alternatively, the PRSBM may be more appropriately divided into abbreviated versions (e.g., PRSBM-checking; PRSBM-avoidance). This may offer a more rapid and focused assessment of safety-seeking behaviours, but whether it is sufficiently comprehensive needs clarifying. Finally, comparing safety-seeking behaviours on the PRSBM with clinician assessed safety-seeking behaviours may give an indicator of its validity. A challenge is that the PRSBM may prompt respondents to then report those behaviours in therapy, however, randomising the order of assessment may help overcome this. After further exploratory work, confirmatory psychometrics can then be considered (Cappelleri et al., 2014).

18.6 Clinical and Policy Implications

Older victims who avoid leaving their home, or going places they were previously able to, suggests that crime may be a 'tipping point' for loss of independence. This is defined as a seemingly abrupt or severe event, affecting an older adult's self-care ability (Crist et al., 2019). These older victims may therefore be important priorities for intervention. Maintaining autonomy in older adults is important for dignity, health, quality of life, longevity, and prevention of cognitive deterioration, so is considered essential for successful ageing (Sanchez-Garcia et al., 2019). It also helps reduce frailty and social isolation, both of which significantly increase the risk of nursing home placement (Gerst-Emerson & Jayawardhana, 2015; Hoogendijk et al., 2019; Kojima, 2018). Prolonged heightened fear in the subset of older victims who were hypervigilant within their homes, as well as avoidant, may be particularly damaging (Golovchanova et al., 2023; Hadida-Naus et al., 2023). Further research is therefore needed to clarify the impact of post-crime avoidance on subsequent functioning. However, if targeting avoidance were found to help older victims maintain independent living, this could offer considerable personal

benefits as well as cost-savings to the tax-payer (Government Office for Science, 2019). Taken together, my study has potentially identified a major preventable public health problem.

Disengaging from safety-seeking behaviours is an important target in cognitive-behavioural therapy (CBT), but it is debated whether all behaviours should be eliminated or whether some may be beneficial (Blakey & Abramowitz, 2016; Rachman et al., 2008). Whilst subtle behaviours like checking were associated with continued psychological distress, they may actually be important for maintaining functioning. Prioritising outright avoidance before targeting other safety-seeking behaviours may be necessary to reduce unintended consequences and attrition from therapy (Rachman et al., 2008). Despite widely-held concerns about the suitability of CBT for older adults (Frost et al., 2019; Laidlaw, 2019), mounting evidence supports its efficacy (Werson et al., 2022). Training therapists in CBT modified for application in older crime victims may improve their confidence when working this population and help address this unmet need (Serfaty et al., 2020).

18.7 End of Section Summary

My systematic review and qualitative study had both observed older victims reporting changing their behaviour after a crime but whether these may be safety-seeking behaviours had not yet been considered. I aimed to address this, but found that existing safety-seeking tools were not suitable because they were not applicable to crime victims and did not consider individual behaviours. I therefore designed, pre-tested, and conducted preliminary evaluation of a novel patient-reported safety-seeking measure. I found that older victims reported a wide-range of behaviours conceptually consistent with their experiences: some highly restrictive, others appeared to help maintain

independence. A change in avoidance was most strongly associated with psychological distress. My measure was acceptable, comprehensive, and appears promising as a tool for researchers and clinicians.

Part V:

Conclusions

Chapter 19: Final Discussion

Supporting older victims of community crime is an issue of mounting social concern with population ageing (Burnes et al., 2017), however, studies to date have predominantly focused on elder abuse, domestic violence, or younger victims (e.g., Ballentine, 2023; Gonggrijp et al., 2023; Knight & Hester, 2016; Yunus et al., 2019). My thesis therefore aimed to address a gap in the evidence on psychological impact and coping in older victims of community crime. I did this by conducting:

1) A systematic review and quality appraisal of the existing global literature on psychological impact and interventions in older crime victims.

2) An inductive qualitative study on how life experiences shape psychological impact and coping in older crime victims.

3) A mixed-methods study to investigate whether safety-seeking behaviours are associated with continued psychological distress in older crime victims. This included the design, pre-testing, and preliminary evaluation of a novel patient-reported measure.

19.1 Overall Findings

In combination, my studies suggest that the psychological impact of crime in older victims varies depending on their individual coping, but that the adverse consequences in those affected may be severe. This included continued symptoms of psychological distress, conflict with beliefs or spiritual struggles, anger, feeling let down, and safety-seeking behaviours. Psychological impact appeared to have wider implications for older victims' health, independence, and quality-of-life. Older victims' earlier life experiences shaped how they appraised the crime, which was found to be important for coping. Those who

were coping well often had explanations for their experience which were compatible with their values, whilst distressed older victims struggled to make sense of what happened. This informed a conceptual framework of coping pathways to guide researchers and clinicians new to the area. I also found through initial development of a Patient-Reported Safety-Seeking Behaviour Measure that this is a useful approach for understanding older victims' core concerns and behavioural responses to the crime. My findings supported that appraisal-focused interventions may be suitable for this population, but to date only feasibility studies have been published.

19.2 Strength and Limitations of my Overall Thesis

My combined studies contribute new evidence on an overlooked population. I have discussed the strengths and limitations of each study separately, but when viewed overall, my thesis was strengthened by its methodologies. Systematic reviews are considered the gold standard of evidence synthesis (Munn et al., 2018), and combining quantitative and qualitative methods achieves a more comprehensive understanding as it harnesses the benefits of each approach whilst compensating for their weaknesses (Creswell, 2009). I further strengthened the evidence by considering healthy coping alongside dysfunctional coping, and using both established (e.g., thematic analysis, logistic regression) and newer techniques (e.g., PROMs, Unique Variable Analysis). A potential weakness of using diverse methods is that each study considered older victims from different perspectives instead of expanding on the study before. However, breadth is considered an essential starting point for new research areas as it lays the foundations for holistic knowledge, which future research can then examine in-depth (Han et al., 2022).

The PRSBM was the most innovative part of my thesis as it improved knowledge on safety-seeking behaviours and PROM methodology as well as older victims. The PRSBM appears promising as a tool for older victims and other populations who may present with safety-seeking behaviours after an adverse event. My thesis was also impactful by developing a conceptual framework to help clinicians better understand older victims and by informing policy implications for criminal justice services. My findings have informed a culturally-responsive therapy manual for victims of hate crime and generated further research, including four MSc projects, a grant application to the NIHR-PHR, and NIHR-funded PPI focus groups.

19.2.1 The VIP Trial

The advantage of embedding my thesis within the VIP Trial was that it utilised an already established collaboration with the police. This facilitated identification and assessment of older victims at a defined timepoint. As previous research had often used convenience samples or asked about crimes from many years previously, this approach strengthened the evidence-base. It also enabled me to use the sociodemographic and GAD-2 and PHQ-2 data that had already been collected. The GAD-2 and PHQ-2 are rapid, reliable, and strongly correlated with the GAD-7 and PHQ-7, which makes them robust indicators of distress (Spitzer et al., 2006).

A disadvantage of embedding my research within the VIP Trial was that I could only include older victims who reported their crime to the police. My thesis may have underrepresented older victims from ethnic minorities or with complex care needs who are less likely to report (Jones & Elliott, 2018; McCart et al., 2010) and overrepresented property crimes, which are often reported to support insurance claims (Xie & Baumer, 2019). Although my qualitative study used purposive sampling with the aim of

identifying older victims from underrepresented groups, there may still be differences in the perspectives of older victims who report their crimes compared to those who do not.

Another limitation was that the VIP Trial excluded sexual crimes because its intervention was not considered suitable, however, this may be especially distressing in older victims. Excluding it from research risks perpetuating the misconception that it does not occur in older people (Bows, 2022). Whilst my systematic review sought to include studies on sexual violence in older victims, I identified just one case study that constituted a community crime (Tyra, 1996). Further research to understand the psychological impact of sexual violence in older victims is therefore needed.

The VIP Trial design required my data collection to be embedded at three months' post-crime (Step 2). I could not collect data immediately after the crime (Step 1) because data protection regulations required the police to complete this and asking them to collect additional data was impractical. I also could not collect follow-up PhD data after three months (at Step 3) because I was blinded to allocation in the VIP RCT. This meant that I could not investigate causal relationships or psychological impact over longer periods. I also could not conduct prospective research as it is not feasible to identify older victims before a crime occurs and a cohort study was not realistic with existing resources. However, embedding my thesis at three months enabled in-depth examination of continued psychological impact, which is considered more clinically relevant than distress immediately after the crime (Horwitz, 2007).

19.3 How Does My Thesis Make a Significant Contribution to Knowledge?

My thesis presents new knowledge on psychological impact and coping in older victims of community crime. This includes a synthesis and appraisal of the existing literature,

new evidence using mixed methods, expansion of coping theory, identifying how research may be strengthened, the development of new assessment tools and resources, and recommendations for further research, policy, and practice. This targets a knowledge gap, as victim studies had previously focused on elder abuse, domestic violence, or younger victims (e.g., Ballentine, 2023; Janssen et al., 2020). By applying the WHO Violence Typology (World Health Organisation, 2023), I also clarified how community crime differs from elder abuse and domestic violence, so that the specific needs of this group could be considered.

My thesis also contributes to wider fields. It responded to calls for more life-course research on coping in older adults (UN Decade of Healthy Ageing, 2021-2030). It identified an issue with safety-seeking behaviour assessment and developed an alternative method with broad applicability. This process also contributes to understanding of PROM evaluation (Ashworth et al., 2019). My findings on broader coping processes may also be relevant to other victim groups. For example, my results dispute what appears to be a widely held perception that certain demographic groups are more adversely impacted than others (Iganski & Lagou, 2015; Norris, 1992a; Tan & Haining, 2016), and caution that blanket conclusions may be harmful, as they risk excluding vulnerable people within these groups.

19.4 The 'So-What' Question: Why Do My Findings Matter?

Psychological distress goes beyond emotional suffering (Drapeau et al., 2012). My thesis suggests it has further consequences for health, quality-of-life, faith, social engagement, and independence. It was nearly two decades ago that older victims were first reported to be at increased risk of accelerated mortality and nursing home admission (Donaldson, 2003; Lachs et al., 2006). Since then, the numbers of older adults aged 65 or over in the

United Kingdom has grown to over 11 million (ONS, 2023e), 97.5% of which live in the community (ONS, 2023d). With increasing numbers of older people, a greater portion of crime victims are older adults (Kratcoski & Edelbacher, 2021). When considered at the population level, the potential scale of psychological impact in older victims is extensive, with significant personal and financial costs. As services are poorly equipped to support older victims (e.g., Commissioner for Older People for Northern Ireland; COPNI, 2023; HMICFRS, 2019), there appears to be substantial unmet need.

My findings matter because they provide updated evidence at a crucial time. The needs of victims are starting to gain recognition from policymakers. In 2023, a £3 million annual investment package for victim care in London was announced (Mayor-of-London, 2023b), an Economic Crime Victim Care Unit was rolled out across England and Wales (City of London Police, 2023a), and the MPS committed to training their officers in compassionate, evidence-based victim care (MPS, 2023b). The new Health and Care Act (2022) also introduced legislative powers enabling the NHS and other public services to provide joined up care (The King's Fund, 2022).

The evidence I present advocates for older victims of community crime to be considered eligible for this support. The potential consequences of crime in this population suggests they may be important targets from a public health perspective. However, they appear to have been overlooked, possibly due to unconscious bias amongst researchers, policy makers, and frontline professionals around which crimes and victim groups most warrant help. Support should therefore be offered to those who present as distressed, rather than those assumed to be most in need based on certain sociodemographic or crime characteristics. Not only would this alternative approach benefit older victims in distress, but it would also enable targeted help to be extended to

vulnerable victims more widely. This may be a more effective allocation of finite public resources.

19.5 Take-Home Messages and Key Recommendations

Not all older victims suffer psychological distress, but the consequences in those who do may be severe.

Policy

Community crime in older victims appears to be a public health problem. Whilst crime prevention is important (UK Government, 2021), it is also crucial that targeted victim care is available. Victims presenting as distressed should be considered eligible, rather than only victims of certain crimes or sociodemographic characteristics. Further development of harm severity metrics is also needed as The Cambridge High Harm Index and The Crime Severity Score (ONS, 2022c; Sherman et al., 2016) do not account for individual impact in their assessment of harm.

Clinical Practice

Coping appears to be shaped by personal perspective. CBT may be appropriate as it works therapeutically with appraisals, targets safety-seeking behaviours, is being tested in older victims, and its efficacy in older adults is well-established (Serfaty et al., 2020; M. Serfaty et al., 2016; Werson et al., 2022). Use of the Patient-Reported Safety-Seeking Behaviour Measure may facilitate therapeutic discussion and focus treatment towards personally relevant unhelpful behaviours. However, only feasibility research on CBT in older victims has been published to date (Serfaty et al., 2016). The effectiveness of other appraisal-focused therapies (e.g., ACT, schema therapy) and non-appraisal interventions

(e.g., psychoeducation) are also yet to be established. Research is ongoing to assess the extent to which older victims seek help for psychological distress, which may inform the most suitable delivery of treatment (Serfaty et al., in prep). Faith is important to many older victims, so clinicians should engage with this therapeutically and not alienate older victims by neglecting, rejecting, or challenging their beliefs.

Police

As older victims' first point of contact, the police may be important for supporting recovery. It may not be realistic to resolve all crimes, but communication, especially during the initial crime report, appears pivotal. Acknowledging that the person has been wronged and expressing empathy for their experience may help older victims to feel heard. Officers should be mindful that visible or tangible damage (e.g., physical injury, substantial loss) may not be necessary for psychological distress to occur and be careful not to undermine or dismiss distressed older victims by suggesting otherwise. Police training on psychological impact in older victims and empathetic communication is recommended.

Spiritual and Religious Support

Some older victims may prefer to seek support through their faith instead of healthcare services or the police. Relationship building with leaders of different faiths to explore how pastoral support may be offered is recommended. Community support through non-secular organisations should also be considered.

Research

Engaging older victims excluded from my thesis is important to further understand psychological impact, and to assess prevalence rates and interventions in representative samples. Collaboration with PPI members and multiple community partners may help facilitate this. Researchers are advised to use reporting guidelines and to specify which crimes are eligible, the duration between crime and assessment, and their philosophical assumptions. Funders are also encouraged to recognise crime as both a public health and social concern and to consider joining up funding streams where needed.

19.6 Final Conclusion

The psychological impact of crime in older victims varies, but the consequences for health, independence, and quality-of-life can be severe. Clarifying individual coping and targeting interventions to those in distress is crucial for supporting this population. My thesis provides up-to-date evidence and possible solutions for a pressing public health challenge at a crucial time.

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Appendix 1: Declaration of Support Received for my Thesis

Background	-I researched and wrote the background chapter independently. - Data on older crime victims was provided by the MPS through personal communication for the VIP Trial. - I received feedback from my supervisors.
Systematic Review	- I designed the review, piloted the search strategy, screened all results, extracted data from all eligible studies, quality appraised all studies, synthesised and wrote the review, and submitted for publication (Satchell et al., 2022). - A librarian advised on my search strategy and the VIP TMG provided feedback on my Prospero protocol. - A research assistant helped upload search results into EndNote and Rayyan in preparation for screening, conducting second screening on all results, and data extraction and quality appraisal on randomly selected 20% of results. - I received feedback from my supervisors, co-authors on the paper, and peer-reviewers.
Qualitative Study	- I researched the relevant literature, designed the study and topic guide, identified and scheduled 25 interviews, conducted all 27 interviews, transcribed 6 interviews, checked and analysed all 27 interviews, wrote-up the study, developed the conceptual framework, and submitted for publication. - My study was embedded with VIP Trial research visits and the trial co-ordinator identified and arranged two interviews. - As religious and spiritual coping was an unanticipated theme, I supervised an MSc student to conduct additional coding on this, which we incorporated into my broader framework. The MSc student also collaborated on a paper on religious and spiritual coping in older victims (Satchell et al., 2023). - I consulted Rev Dr Sarah McDonald Haden on the religious and spiritual aspects of my findings.

	- Another MSc student and professional transcriber transcribed 21 interviews, in line with GDPR and ethical approval for the study (Appendix 3). - Another MSc student posted 100 letters to Step 1 screen negative older victims inviting anyone who felt they may be experiencing delayed symptoms to be involved in interviews. I received feedback from my supervisors, co-authors on the paper and peer reviewers.
Mixed-Methods Study	- I researched the relevant literature, designed the study, designed the PRSBM, collected and summarised all pre-testing data, collected all data in the larger sample, completed qualitative and quantitative analysis, and wrote up the study. - The PRSBM was refined through internal review with the VIP TMG, who approved a version for further testing. This included two older victim PPI members who gave detailed feedback on the PRSBM including its usability and acceptability. - My statistical analysis plan was supported by three statisticians. A statistician also provided guidance on using *R* to complete the Unique Variable Analysis. - I received feedback from my supervisors. - I received additional feedback and advice from Prof Chris Brewin and Dr Gary Brown, who are co-authors on a manuscript in preparation.
Conclusions	- I researched and wrote the final conclusions. - I received feedback from my supervisors.
Ethics	- I received ethical approval for my studies (Appendix 3), discussed in further detail in the relevant chapters. - Prof Robert Howard, Dr Martin Blanchard, and the VIP Trial PPI members advised on ethical considerations when working with older people in research.
Financial	The VIP Trial was funded by the NIHR-PHR (13/164/32), which I was paid a salary to work on. I self-funded my tuition fees but received support from the UCL Study Assistance Scheme.

Appendix 2: Crimes Eligible for Inclusion

A table of crimes eligible for inclusion in the VIP Trial. For definitions of crime types, see: https://www.met.police.uk/sd/stats-and-data/met/crime-type-definitions/

Crime Description	Crime Group
Arson to a Dwelling-Endanger Life	Arson
Arson-Dwelling-No Danger to Life	Arson
Racial Arson Dwell Endanger Life	Arson
Racial Arson-Dwell-No Danger Life	Arson
Arson-Oth Building-Endanger Life	Arson
Arson-Oth Building-No Danger Life	Arson
Racial Arson Oth/Build-Endan Life	Arson
R/Arson-Oth/Build No Danger Life	Arson
Arson-Motor Vehicle-Endanger Life	Arson
Arson-Motor/Veh-No Danger to Life	Arson
Racial Crim/Dam M/V-Endanger Life	Criminal Damage endangering life
Racial Arson M/V-No Danger Life	Arson
Arson-Oth Property-Endanger Life	Arson
Arson-Oth Prop-No Danger to Life	Arson
Racial Arson Oth/Prop-Enda Life	Arson
R/Arson Oth/Prop-No Danger Life	Arson
GBH/Serious Wounding	Assault with injury
ABH	Assault with injury
Religious Aggravated GBH/Wound	Assault with injury
Racial/Religious GBH/Wound	Assault with injury
Racially/religious Agg harassment	Stalking or Harassment
Racially/religious Agg Assault	Assault with injury
Racially/religious Agg harassment	Stalking or Harassment
Racially/religious Agg GBH	Assault with injury
Racially/religious Agg ABH	Assault with injury
Stalking Fear Of Violence	Stalking or Harassment
Stalking Serious Alarm Distress	Stalking or Harassment
GBH with Intent	Assault with intent to commit GBH
Burglary Dwell - Indictment Only	Burglary
Dist Burg Dwell - Indictment Only	Burglary
Burglary in a Dwelling - Violence	Burglary
Dis Burg in a Dwelling - Violence	Burglary
Burglary in a Dwelling.	Burglary
Dist. Burglary in a Dwelling.	Burglary
Burglary Res Artifice/Distraction	Burglary
Aggravated Burglary In Dwelling	Burglary
Common Assault	Common assault
Crim/Dam. Dwelling - over £5000	Criminal Damage
Racial Crim/Dam Dwell over £5000	Criminal Damage
Crim/Dam.Oth Building-Over £5000	Criminal Damage
Racial Crim/Dam-Oth/Build + £5000	Criminal Damage
Crim-Dam to M/Veh - over £5000	Criminal Damage
Racial Crim/Dam-To M/V over £5000	Criminal Damage
Crim.Dam-Other Prop - over £5000	Criminal Damage
Racial Crim/Dam -Oth/Prop + £5000	Criminal Damage
Crim Dam Dwelling - under £500	Criminal Damage
Crim Dam Dwelling - £500 to £5000	Criminal Damage
Racial Crim Dam Dwelling < £500	Criminal Damage
Race Crim Dam Dwelling £500-£5000	Criminal Damage
Crim Dam Other Building < £500	Criminal Damage
CrimDam-Other Building £500-£5000	Criminal Damage
Racial CrimDam-Oth/Building <£500	Criminal Damage
R/Crim/Dam-Oth/Build-£500 - £5000	Criminal Damage
Crim Dam to M/Veh - under £500	Criminal Damage
Crim Dam to M/Veh - £500 to £5000	Criminal Damage
Racial Crim/Dam to M/V Under £500	Criminal Damage
Racial Crim/Dam-M/V £500 to £5000	Criminal Damage
Crim Dam-Other Prop under £500	Criminal Damage
Crim Dam-Other Prop £500 to £5000	Criminal Damage
Racial Crim/Dam Oth/Prop < £500	Criminal Damage
Racial CrimDam-Oth/Prop£500-£5000	Criminal Damage
Crim/Dam. Dwelling -Endanger Life	Criminal Damage endangering life
Racial Cr/Dam Dwell Endanger Life	Criminal Damage endangering life
Crim/Dam.Oth Build-Endanger Life	Criminal Damage endangering life
R/Crim/Dam-Oth/Build-Danger Life	Criminal Damage endangering life
Crim-Dam to M/Veh-Endanger Life	Criminal Damage endangering life
Racial Crim/Dam-M/V-Endanger Life	Criminal Damage endangering life
Crim.Dam-Other Prop-Endanger Life	Criminal Damage endangering life
R/Crim/Dam-Oth/Prop-Endanger Life	Criminal Damage endangering life
Non Crime Fraud - Action Fraud	Fraud
Non Crime Cyber Crime - AF	Fraud
Robbery of Personal Property	Robbery
Personal Robbery from Agg Burg	Robbery
Course Of Conduct - Stalking	Stalking or Harassment
Harassment	Stalking or Harassment
Theft in a Dwelling	Theft Dwelling
Theft from Motor Vehicles	Theft from vehicles
Theft from Other Vehicles	Theft from vehicles
Aggravated Taking - Death Caused	Theft or taking of motor vehicle
Aggravated Taking - No Fatality	Theft or taking of motor vehicle
Theft of Motor Vehicle	Theft or taking of motor vehicle
Unauthorised Taking Motor Vehicle	Theft or taking of motor vehicle
Unauth.Taking - Other Conveyance	Theft or taking of motor vehicle
Agg Taking - Damage under £5001	Theft or taking of motor vehicle
Theft of Pedal Cycles	Theft or taking of Pedal Cycle
Take Pedal Cycle Without Consent	Theft or taking of Pedal Cycle
Theft Not Classified Elsewhere	Theft Other
Theft of Other Conveyance	Theft Other
Theft From The Person of Another	Theft Person

Appendix 3: Sociodemographic Information and GAD-2 and PHQ-2 Screening Tools

UCL

VIP TRIAL DEMOGRAPHICS AND SCREENING SHEET

METROPOLITAN POLICE
TOTAL POLICING

SCREENING ID Initials ☐☐ Site ☐☐☐☐ Subject ☐☐☐☐☐

1) Date of birth (if known) _____ A/Age_____ 2) Gender _____

3) Self defined ethnicity

A1 Asian - Indian	M1 Mixed - White and Black Caribbean	B1 Black - Caribbean	W1 White - British
A2 Asian - Pakistani	M2 Mixed - White and Black African	B2 Black - African	W2 White - Irish
A3 Asian - Bangladesh	M3 Mixed - White and Asian	B3 Black - Other	W3 White - Other
A9 Asian - Other	M4 Mixed - Other mixed background	O1 Chinese or Other	O9 Other ethnic group

4) Victim vulnerability (as shown on CRIS): _____

5) STATUS - What best describes your current status? (Please tick one)

☐ Single ☐ Married ☐ Cohabiting ☐ Widow / Widower
☐ Divorced ☐ Seperated ☐ Other_____

6) EDUCATION - Please describe your level of education: (Please tick one)

☐ Primary (Up to 14 years) ☐ Secondary (Up to 18 years) ☐ Higher (Degree or equivalent

7) WORK: What work did you and your spouse do before you retired or what do you currently do if not reti

Self: _____ Spouse: _____

8) CURRENT LIVING ARRANGEMENTS

☐ Private rented ☐ Residential Care Home ☐ Owner / Occupier
☐ Housing Association rented ☐ Nursing home ☐ Hostel
☐ Council rented ☐ Other_____

9) Crime Date_____ 10 Crime Desc._____

11) Crime Group_____ 12) Crime Code_____

13 Has anyone been arrested in relation to the crime? ☐ Yes ☐ No

14 Have you been a victim of any other crime in the last 12 mont ☐ Yes ☐ No

15 Has the crime affected your daily life? ☐ Yes ☐ No

16 Have you ever previously suffered from depression or anxiety ☐ Yes ☐ No

17 In the past week how many friends/ relatives have you seen or had contact with? Number___

18) Before the crime what was your sense of saf	Very safe	Safe	Neither safe nor unsafe	Unsaf	Very unsafe
19) Since the crime what is your sense of safety	Very safe	Safe	Neither safe nor unsafe	Unsafe	Very unsafe

Priment Clinical Trials Unit

Completed by Print Name Signature

Completed on D D M M 2 0 Y Y

VIP TRIAL DEMOGRAPHICS AND SCREENING SHEET

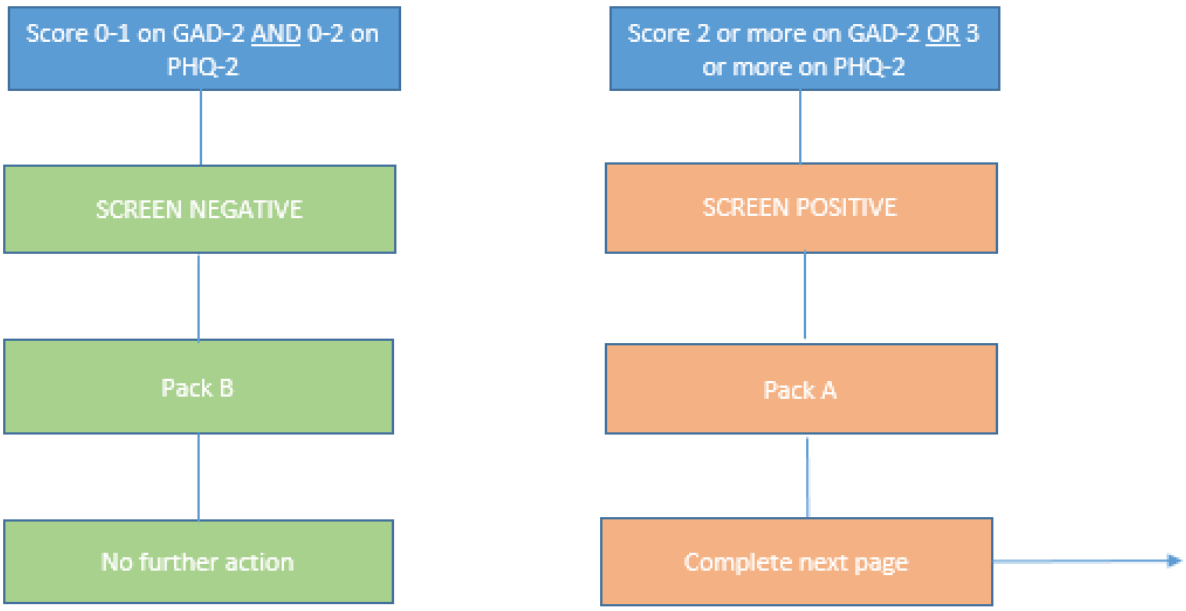
SCREENING ID | Initials | Site | Subject

GAD-2 Scale				
Over the last 2 weeks how often have you been bothered by the following problems ? (Use "✓" to indicate your answer)	Not at all	Several days	More than Half the days	Nearly every day
1. Feeling nervous, anxious, on edge	**0**	**1**	**2**	**3**
2. Not being able to stop or control worrying	**0**	**1**	**2**	**3**

ADD QUESTION 1 and 2 for Total Score (2 OR MORE = POSITIVE) =_____.

PHQ-2 Scale				
Over the last 2 weeks how often have you been bothered by the following problems ? (Use "✓" to indicate your answer)	Not at all	Several days	More than Half the days	Nearly every day
3. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
4. Feeling down, depressed and hopeless	**0**	**1**	**2**	**3**

ADD QUESTION 3 and 4 for Total Score (3 OR MORE = POSITIVE) =_____.



Completed by | Print Name | Signature | Completed on DD MM 20YY

Appendix 4: Research Ethics Committee (REC) Approval

4.1 The VIP Trial REC Approval

UCL RESEARCH ETHICS COMMITTEE
ACADEMIC SERVICES

17 March 2016

Dr Marc Serfaty
Department of Epidemiology and Applied Clinical Research
Division of Psychiatry
UCL

Dear Dr Serfaty

Notification of Ethical Approval
Project ID: 6960/001: The VIP Trial: a randomised controlled trial of the clinical and cost effectiveness of a Victim Improvement Package (VIP) for the reduction of chronic symptoms of depression or anxiety in older victims of common crime

I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been approved by the UCL REC for the duration of the project i.e. until 31st December 2019.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form': http://ethics.grad.ucl.ac.uk/responsibilities.php

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

   For non-serious adverse events the Chair or Vice-Chair of the Ethics Committee should again be notified via the Ethics Committee Administrator (ethics@ucl.ac.uk) within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

On completion of the research you must submit a brief report of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

Yours sincerely

[redacted]

Professor John Foreman

Academic Services, 1-19 Torrington Place (9th Floor),
University College London
Tel: +44 (0)20 3108 8216
Email: ethics@ucl.ac.uk
http://ethics.grad.ucl.ac.uk/

Amending an Approved Application

Should you wish to make an amendment to an approved study, you will need to submit an 'amendment request' for the consideration of the Chair of the UCL Research Ethics Committee. Applications can only be amended **after** ethical approval has been granted.

You will need to apply for an amendment approval if you wish to:

1. Add a new participant group;
2. Add a new research method;
3. Ask for additional data from your existing participants;
4. Remove a group of participants or a research method from the project, and have not yet commenced that part of the project;
5. Apply for an extension to your current ethical approval.

If you need to apply for an amendment approval, please complete the Amendment Approval Request Form on the next page.

When completing the form, please ensure you do the following:

- Clearly explain what the amendment you wish to make is, and the justification for making the change.
- Insert details of any ethical issues raised by the proposed amendments.
- Include all relevant information regarding the change so that the Chair can make an informed decision, and submit a copy of the sections of your application that have changed with all changes highlighted/underlined for clarity.
- You do not need to submit your original application in full again. However, if the changes you wish to make alters several sections of your application form, you are advised to submit this.

One signed hard copy of the form (and any amended documents), as well as an electronic copy of these same documents must be submitted to the REC Administrator to the address detailed below:

Administrator of the UCL Research Ethics Committee
Academic Services
1-19 Torrington Place
UCL
London
WC1E 6BT

Email: ethics@ucl.ac.uk

Amendment requests are generally considered within 5-7 days of submission.

Appendix 4.2: REC Amendment Form for Qualitative Study

UCL RESEARCH ETHICS COMMITTEE

Amendment Approval Request Form

1	**Project ID Number:** 6960/001	**Name and Address of Principal Investigator:** Dr Marc Serfaty, Department of Epidemiology and Applied Clinical Research, Division of Psychiatry, University College London, 6th Floor, Maple House, 149 Tottenham Court Road, London W1T 7NF.
2	**Project Title:** The VIP trial: a randomised controlled trial of the clinical and cost effectiveness of a Victim Improvement Package (VIP) for the reduction of chronic symptoms of depression or anxiety in older victims of common crime.	
3	**Type of Amendment/s (tick as appropriate)** Research procedure/protocol (including research instruments) ☐ Participant group ☐ Sponsorship/collaborators ☐ Extension to approval needed (extensions are given for one year) ☐ Information Sheet/s ☐ Consent form/s ☐ Other recruitment documents ☐ Principal researcher/medical supervisor* ☐ Other X *Additions to the research team other than the principal researcher, student supervisor and medical supervisor do not need to be submitted as amendments but a complete list should be available upon request.	
4	**Justification** (give the reasons why the amendment/s are needed) Qualitative interviews around help-seeking and experiences of services are already planned as part of the VIP trial. However, these interviews will now form part of the PhD which is being embedded within the trial. Slight modifications to the procedure are therefore necessary. The content of the interviews has also been adapted to include other topics of interest for the PhD student.	
5	**Details of Amendments** (provide full details of each amendment requested, state where the changes have been made and attach all amended and new documentation) • Help-seeking and experiences of services will still be discussed in the interviews. However, the interviews will now also enquire about changes to behaviour that may have happened since the crime (safety behaviours) and how childhood experiences influence interpretations of the crime. • The interviews will not now begin by discussing the crime. Instead, the aim is to develop a narrative of before the crime (early life experiences), the crime itself, and after the crime (safety behaviours, help-seeking). • Instead of interviewing 15-24 participants, the aim is now to interview up to 30 participants.	

	• The interviews will still aim to include a mixture of genders, ethnicities and screen negative and screen positive participants. However, the interviews now also aim, if possible, to include a mixture of people who did and did not take their letter from the police SNT to their GP. • As the interviews form part of a PhD, the PhD student will predominantly be indexing and coding the data (as opposed to two researchers as outlined in the protocol). This work will be supervised by the principal investigator for the VIP trial and the secondary supervisor for the PhD, who has expertise in qualitative methods and trauma research. An MSc student may assist with tasks such as transcription or small amounts of coding. • The topic guide is attached. However, it will be an iterative process so the questions will be developed as the interviews are conducted and unanticipated topics of interest will be included.
6	**Ethical Considerations** (insert details of any ethical issues raised by the proposed amendment/s) The same ethical considerations as outlined before will continue to apply. It is possible that interviewees may find talking about the crime or their childhood (especially if they have had a traumatic childhood) distressing. However, two academics in older age psychiatry were consulted around this and both felt that such research was acceptable and important. Avoidance of research based on the age of the population is stigmatising and discriminatory, counter to guidelines on socially inclusive practice (Taylor & Gosney, 2011; APA, 2014; Principle E of the APA Ethics Code, 2002a, 2010a). Efforts to minimise distress will include explaining to participants that a) they do not have to answer any questions they do not feel comfortable with and can end the interview at any time b) that their interviews will be anonymised and c) declining to answer the questionnaire will not affect their involvement in the larger VIP trial.
7	**Other Information** (provide any other information which you believe should be taken into account during ethical review of the proposed changes)

Declaration (to be signed by the Principal Researcher)

- I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
- I consider that it would be reasonable for the proposed amendments to be implemented.
- For student projects I confirm that my supervisor has approved my proposed modifications.

Signature: [redacted]

Date: 04/05/2018

FOR OFFICE USE ONLY:

Amendments to the proposed protocol have been approved by the Research Ethics Committee.

Signature of the REC Chair: [redacted] (Prof. M. Heinrich)

Date: 24/5/2018

Appendix 4.3: REC Amendment Form for Safety-Seeking Behaviours Study

UCL RESEARCH ETHICS COMMITTEE

Amendment Approval Request Form

1	**Project ID Number:** 6960/001	**Name and Address of Principal Investigator:** Dr Marc Serfaty, Department of Epidemiology and Applied Clinical Research, Division of Psychiatry, University College London, 6th Floor, Maple House, 149 Tottenham Court Road, London W1T 7NF.
2	**Project Title:** The VIP trial: a randomised controlled trial of the clinical and cost effectiveness of a Victim Improvement Package (VIP) for the reduction of chronic symptoms of depression or anxiety in older victims of common crime.	
3	**Type of Amendment/s (tick as appropriate)** Research procedure/protocol (including research instruments) X Participant group ☐ Sponsorship/collaborators ☐ Extension to approval needed (extensions are given for one year) ☐ Information Sheet/s ☐ Consent form/s X Other recruitment documents ☐ Principal researcher/medical supervisor* ☐ Other ☐ *Additions to the research team other than the principal researcher, student supervisor and medical supervisor do not need to be submitted as amendments but a complete list should be available upon request.	
4	**Justification** (give the reasons why the amendment/s are needed) Additional research is being imbedded within the VIP trial for the purposes of a PhD. The design of the VIP trial will not change but additional questionnaires will be administered. The VIP trial is amongst the first to study the psychological impact of common crime in older people, and the design of the study offers valuable opportunities for further research.	
5	**Details of Amendments** (provide full details of each amendment requested, state where the changes have been made and attach all amended and new documentation) The Childhood Trauma Questionnaire – Short Form (CTQ-SF) will be used to assess for childhood experiences of emotional, physical and sexual abuse, and emotional and physical neglect. It will be administered: • In step 2, to as many of the step 1 screen positive and screen negative older adults as possible. o Of the step 1 screen positive older victims who complete the CTQ-SF during step 2 of the trial and also proceed to step 3, the measure will be administered again at the end of the intervention phase to see whether results on this questionnaire are influenced by mood.	

	• A measure assessing safety behaviours that older adults may develop in response to crime will be administered during step 2 of the trial. There are no suitable existing measures so it has been necessary to create one for the purposes of this study. o The aim is to pre-test the measure in 5 – 10 people in the first instance (depending on the point that saturation is reached). The aim is to include both screen positive and screen negative older victims from step 1 of the trial. If changes to the measure are warranted after this, a new amendment request will be submitted. o The measure will then be administered to a development sample of 70 - 100 people,including those who screened positive and those who screened negative at step 1, to enable assessment of the measure's psychometric properties. The measure will be re-administered to 30 of these participants a second time to assess test re-test reliability. o Once development of the measure is complete, it will be administered to as many people in step 2 of the trial (step 1 screen positive and negative) as possible so that prevalence of safety behaviours in the sample can be determined. o Of the older victims who proceed to step 3 of the trial, the measure will be administered again at the end of the intervention phase and at follow up. • Adaptation to the consent form used in step 3asking whether participants consent to their task sheet on safety behaviours worked on during Mind therapy sessions being uploaded to Data Safe Haven. Access to this data will enable a comparison between safety behaviours reported on the measure and safety behaviours reported during the Mind therapy sessions, which may help determine the validity of the measure.
6	**Ethical Considerations** (insert details of any ethical issues raised by the proposed amendment/s) **The Childhood Trauma Questionnaire – Short Form** • **Quality of the measure:** The CTQ-SF it is the most widely-used and investigated scaled approach to measure diverse forms of childhood maltreatment (Spinhoven et al., 2014) and its psychometric properties have been validated and tested (e.g. Bernstein et al., 2003; Gerdner & Allgulander, 2009; Thombs, Bernstein, Lobbestael & Arntz, 2009). • **Respondent burden:** The CTQ-SF is a 28 item measure that takes around 5 minutes to complete (Bernstein et al., 2003). It has been chosen over the longer CTQ to minimise respondent burden. • **Questions related to earlier trauma:** It is possible that participants may find questions related to earlier trauma, especially sexual abuse, distressing. However: o The CTQ-SF is a widely accepted measure and has been used in numerous populations without ethical problems. o Two academics in older age psychiatry were consulted around this and both felt that such research was not just acceptable but important: older adults should have the same opportunities to participate in research as other age groups. o Avoidance of research related to sex, sexuality or sexual problems based on the age of the population is stigmatising and discriminatory, counter to guidelines on socially inclusive practice (Taylor & Gosney, 2011; APA, 2014; Principle E of the APA Ethics Code, 2002a, 2010a). o The CTQ-SF was presented to the Trial Management Group, who raised no objections to its use. o The CTQ-SF was presented to the trial lay reader, who raised no objections to its use. o The CTQ-SF was presented to our advisor from Age UK, who raised no objections to its use.

- Efforts to minimise distress will include explaining to participants that a) they do not have to answer any questions they do not feel comfortable with b) that their responses will be kept confidential and c) declining to answer the questionnaire will not affect their involvement in the larger VIP trial.

Piloting and use of a new measure of safety behaviours

- **Justification for use of a new measure:**
  - There is no existing measure of crime-related safety behaviours that can be used instead.
  - This research could make a significant contribution to the field. Despite the prominence of safety behaviours in cognitive theory and therapy, there is limited empirical evidence to support the concept and there have been almost no previous attempts to explore how safety behaviours develop after the experience of crime. Collecting quantitative data on safety behaviours is necessary to achieve this aim.
  - The new measure also seeks to address methodological limitations that are present in existing (non-crime related) measures of safety behaviours. The development and validation of an alternative measure may be of use to future researchers in the field.

- **Quality of the measure:** Attempts to ensure the quality of the measure so far are:
  - Submitting the measure to professionals advising on the project to ensure face validity.
  - The measure was submitted to our lay reader and his neighbour, who was previously an older victim of crime.
  - Both submitted detailed feedback and the measure was adapted based on this.
  - The measure was presented to the trial management group, who raised no objections to piloting it. (They will review again once the results of the pilot are known).
  - The measure was presented to our advisor at Age UK who raised no objections to its use.

- **Respondent burden:** The measure consists of 7 items and has been purposefully kept brief.

7	**Other Information** (provide any other information which you believe should be taken into account during ethical review of the proposed changes)

Declaration (to be signed by the Principal Researcher)

- I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
- I consider that it would be reasonable for the proposed amendments to be implemented.
- For student projects I confirm that my supervisor has approved my proposed modifications.

Signature: [redacted]

Date: 15/11/2017

FOR OFFICE USE ONLY:

Amendments to the proposed protocol have been approved by the Research Ethics Committee.

Signature of the REC Chair: [redacted] (Dr Lynn Ang)

Date: 28/11/2017

Appendix 4.4 VIP Trial REC Amendment Form: Changes in Consent Procedures at Steps 1 and 2

Amendment Approval Request Form

1	**Project ID Number: 6960/001**	**Name and Address of Principal Investigator:** Dr Marc Serfaty, Department of Epidemiology and Applied Clinical Research, Division of Psychiatry, University College London, 6th Floor, Maple House, 149 Tottenham Court Road, London W1T 7NF
2	**Project Title:** The VIP trial: a randomised controlled trial of the clinical and cost effectiveness of a Victim Improvement Package (VIP) for the reduction of chronic symptoms of depression or anxiety in older victims of common crime.	
3	**Type of Amendment/s (tick as appropriate)** Research procedure/protocol (including research instruments) ☒ Participant group ☐ Sponsorship/collaborators ☐ Extension to approval needed (extensions are given for one year) ☐ Information Sheet/s ☐ Consent form/s ☐ Other recruitment documents ☒ Principal researcher/medical supervisor* ☐ Other ☐ **Additions to the research team other than the principal researcher, student supervisor and medical supervisor do not need to be submitted as amendments but a complete list should be available upon request **	
4	**Justification** (give the reasons why the amendment/s are needed) Currently the study seeks consent from victims of crime at 3 time points: at step 1 (screening), at step 2 (re-screening at 3 months), and at step 3 (randomised controlled trial). Participants have suggested that this represents an excessive amount of paperwork to participate in the trial. By removing the consent at step 2 we hope to reduce participant burden and simplify the trial. The step 1 consent form already contains consent to be contacted for the study at 3 months. It therefore seems unnecessary to consent participants again when we contact them at the 3 month time point.	
5	**Details of Amendments** (provide full details of each amendment requested, state where the changes have been made and attach all amended and new documentation) This study comprises 3 steps: Metropolitan Police Service staff screen victims of crime for distress (step 1); around 3 months after the crime UCL researchers re-screens the victim for continuing distress (step 2); those who remain distressed are offered the opportunity to participate in a randomised controlled trial (step 3). In the initial ethics approval for this study (dated 17/03/16), consent was obtained from the victim of crime at step 2 (re-screening) and step 3 (randomised controlled trial), while the initial step 1 screening involved agreement to contact rather than consent to participate. During the first amendment approved for this study we submitted a consent form to be used by the Metropolitan Police Service when consenting victims for step 1 of the study, VIP Consent step 1 v2.0 25 10 16.docx. This consent form was most recently amendment to VIP Consent step 1 v6.0 11 06 18.xlsx in the amendment approved on the 29/06/18. This approved step 1 consent form is used to gain consent from participants at the first point of entry into the study.	

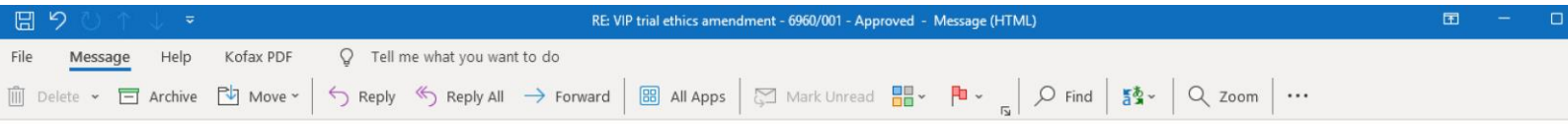
	Participants have suggested to us that they find the amount of paperwork they are completing for the trial excessive, and that they cannot see the need to complete a consent form at each of the three steps of the study. We therefore wish to confirm that, now that we are gaining consent to participate in the study at step 1, it will not be necessary to gain additional consent at step 2 (that is, that the step 1 consent form can be used to gain consent for both the initial screening and the re-screening at 3 months). Using the step 1 consent form to cover both the step 1 (screening) and step 2 (re-screening) will decrease the burden on participants, simplify the process and avoid confusion. Importantly, the step 1 consent form (attached with this amendment) already includes the agreement to be contacted at 3 months for this study. It therefore appears unnecessary to gain consent again at the three month time point. We will continue to gain separate consent for any participant entering the randomised controlled trial (step 3)
6	**Ethical Considerations** (insert details of any ethical issues raised by the proposed amendment/s) Participants already consent at step 1 that they are happy to be contacted for the study at 3 months. Asking them to consent again when we contact them represents an added burden to participants. We hope that removing this extra point of consent will reduce the burden on participants of taking part in the trial. In line with standard ethical guidelines we will continue to obtain consent separately for any participant entering the randomised controlled trial (step 3 of this study).
7	**Other Information** (provide any other information which you believe should be taken into account during ethical review of the proposed changes)

Declaration (to be signed by the Principal Researcher)

- I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
- I consider that it would be reasonable for the proposed amendments to be implemented.
- For student projects, I confirm that my supervisor has approved my proposed modifications.

Signature: 

Date: 15/11/2018



RE: VIP trial ethics amendment - 6960/001 - Approved

AT

Aspden, Trefor
To VPRO.Ethics

Reply | Reply All | Forward

Fri 07/12/201

You replied to this message on 07/12/2018 15:47.

From: VPRO.Ethics <ethics@ucl.ac.uk>
Sent: Friday, December 7, 2018 10:06 AM
To: Aspden, Trefor <[redacted]
Subject: FW: VIP trial ethics amendment - 6960/001 - Approved

Dear Trefor,

Turns out I didn't have to wait long. The REC Chair has **approved** your amendment request with the following proviso.

The Participation Information Sheet and Consent Form for stage one must be adapted (i.e. tailored to your study) and the participants should be reminded verbally that they already consented at Stage one and are free to withdraw a any point in time.

IMPORTANT: For projects collecting personal data only
Change to legal basis for the processing of data: If you are processing (i.e. collecting, storing, using, disclosing or destroying) identifiable personal information about living individuals as part of your research then you should ensure you comply with the requirements of the GDPR and the Common Law Duty of Confidentiality. An appropriate legal basis for the processing of your data must be identified, and you must be explicit about this and document it as pa your ethics application, and in the information you provide to your research participants. UCL's view is that, for the vast majority of research undertaken at UCL, the appropriate legal basis will be 'a task in the Public interest': the processing is necessary for UCL to perform a task in the public interest - rather than 'consent'.

However, even though the legal basis for the processing of a person's data is most likely to be 'a task in the public interest' rather than 'consent', from an ethical perspective, obtaining a person's informed consent for their involve in the research is still likely to be required in order to abide by the fairness and transparency elements of principle GDPR Article 5(1)(a) or to meet confidentiality obligations.

We have recently changed the data privacy section of our template participant information sheet (PIS) to reflect this change to the legal basis for data processing – see attached. You will need to update your PIS accordingly.

With best wishes for the research,

Ed

Appendix 4.5. VIP Trial REC Amendment Form: Follow-up with Step 1 Screen Negative Older Victims

Amendment Approval Request Form

1	**Project ID Number:** 6960/001	**Name and Address of Principal Investigator:** Dr Marc Serfaty, Department of Epidemiology and Applied Clinical Research, Division of Psychiatry, University College London, 6th Floor, Maple House, 149 Tottenham Court Road, London W1T 7NF.
2	**Project Title:** The VIP trial: a randomised controlled trial of the clinical and cost effectiveness of a Victim Improvement Package (VIP) for the reduction of chronic symptoms of depression or anxiety in older victims of common crime.	
3	**Type of Amendment/s (tick as appropriate)** Research procedure/protocol (including research instruments) ☒ Participant group ☐ Sponsorship/collaborators ☐ Extension to approval needed (extensions are given for one year) ☐ Information Sheet/s ☒ Consent form/s ☐ Other recruitment documents ☐ Principal researcher/medical supervisor* ☐ Other ☐ **Additions to the research team other than the principal researcher, student supervisor and medical supervisor do not need to be submitted as amendments but a complete list should be available upon request **	
4	**Justification** (give the reasons why the amendment/s are needed) 1) We have previously had additional research on participants who screen negative for anxiety and depression at step 1 approved. However, we had not previously had an information sheet for these participants approved, and the existing participant information sheet required adaptation as it would not otherwise accurately outline the research that the participant was taking part in. 2) Living alone may be a risk factor for developing chronic distress after a crime, and asking this question will help us to determine what factors protect or make people more vulnerable to developing chronic distress after a crime. 3) At the moment we are excluding participants who wish to take part in the research but are unable to conveniently do so within the specified time window. Extending this time window will allow more individuals to participate if they wish to do so, at a time that is convenient for them. 4) It is important to maintain blinding of researchers in this randomised controlled trial, and these minor changes to the wording of three questions will help to maintain blinding without any loss of information. 5) We are concerned that the MINI neuropsychiatric interview is not picking up people with significant distress. We now have sufficient data to support our concerns. We have observed that a number of people who score highly on the GAD2 go on to screen out of the study on the MINI. This is despite the researchers' observation during step 2 screening that the older victim is significantly distressed at interview. The MINI may not be an accurate way to detect distress in this group, as where anxiety states are concerned the MINI is designed to detect generalised anxiety disorder or Panic. For people who have been victims of crime they have significant anxiety and worry around the crime, but this is not	

	generalised. Furthermore the MINI criteria require the presence of symptoms for 6 months, whereas out target population are being screened within 3 months of the crime.
5	**Details of Amendments** (provide full details of each amendment requested, state where the changes have been made and attach all amended and new documentation) We wish to make the following amendments to the VIP study: 1) A researcher is completing a PhD attached to the VIP study. This research has previously been approved, and we have now also developed an information sheet specifically for this PhD research. This information sheet "VIP-PIS-step 1-screen neg- step 2- v1 30 07 2018" is attached with this amendment package. 2) We wish to add the question: "At the time of the crime were you living alone" to the questionnaire VIP Demographics Step 2 v5 02 02 18. The updated questionnaire, VIP Demographics Step 2 v6 30 07 18, has been attached with this amendment for approval 3) We currently conduct the second screening (step 2) for the VIP study at 3 months after the date of crime, and allow a 4 week window after this for completing the visit. Many victims have expressed a wish to take part but wish to do so several weeks after the date that we are due to visit them, for example because of family events or travel. To avoid excluding these individuals, we therefore wish to expand the window to allow for step 2 screenings at any date between 3 and 5 months after the crime date. The target date will remain 3 months post crime, however we will allow greater flexibility to complete this up to 5 months post crime so as not to unnecessarily exclude people from research. 4) Changing wording for one of our outcome measures, the CSRI. The study researchers have noted that in its current form three of the questions in the adapted CSRI can unblind the researcher to the participant's group allocation. As a result three questions on the CSRI have been changed to include the wording "not related to the trial" after the name of the relevant service. These changes are highlighted in track changes in the attached "VIP adapted CSRI v5.0 30 07 18 track changes" document. 5) Currently entry into the randomised controlled trial requires a victim of crime to screen positive for anxiety on the GAD2 and / or depression on PHQ2, and then to show a positive diagnosis of major depressive episode, panic disorder, or general anxiety disorder on the MINI neuropsychiatric interview. We wish to change these anxiety and depression entry criteria to the first step of this two stage process, that is screening positive on the GAD2 and / or the PHQ2. We will still administer the MINI for information purposes, but the lack of a positive diagnosis on the MINI will not exclude a victim from participating in the trial.
6	**Ethical Considerations** (insert details of any ethical issues raised by the proposed amendment/s) No ethical issues have been identified in relation to this amendment.
7	**Other Information** (provide any other information which you believe should be taken into account during ethical review of the proposed changes)

Declaration (to be signed by the Principal Researcher)

- I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
- I consider that it would be reasonable for the proposed amendments to be implemented.
- For student projects, I confirm that my supervisor has approved my proposed modifications.

Signature: 

Date: 02/08/2018

RE: VIP trial ethics amendment

VPRO.Ethics
To Aspden, Trefor
Cc Serfaty, Marc

Follow up. Start by 04 September 2018. Due by 04 September 2018.

Dear Trefor,

Your amendment request is approved.

Best,

Ed

Edward Whitfield MA, MLitt
UCL Research Ethics Administrator
2 Taviton Street,
London WC1H 0BT
E-mail: ethics@ucl.ac.uk
Tel: +44 (0)20 7679 8878 (Int: 55427)
https://ethics.grad.ucl.ac.uk/

Appendix 5: Participant Information Sheets and Consent Forms

Appendix 5.1 Participant Information Sheet – Step 1

Participant Information sheet
Step 1

Victim Improvement Package (VIP) study: helping distressed victims of crime.

We are genuinely sorry to hear that you have been a victim of crime. Your Metropolitan Police local Safer Neighbourhood Team officer is concerned that this may have caused you some distress and wonders if you may benefit from further support. They have indicated that you would be happy for further contact to discuss this.

Who are we and what would this be about?
Our team consists of experts from the School of Medicine (UCL), the Jill Dando Institute of Crime Science, the Metropolitan Police (Met), Mind counselling service and Age UK.

The police will provide you with some important information about crime prevention and a letter to take to your GP if you wish, to highlight the distressing experience you have been through. We want to talk about this and other opportunities we may have for you.

Why have you been chosen?
Older people may be particularly affected by crime, but this usually gets better with time. We would like to collect some basic information about your background and how the crime has affected you. Our previous work has shown that if you are still distressed after a few months, further support may be very helpful. We will therefore be checking to see how you are doing.

Do you have to take part?
No it is up to you to decide whether or not to take part. Should you decline, please be assured that no further effort will be made to make you reconsider. Even if you do decide to take part you are still free to withdraw at any time and without giving a reason. Your decision will not affect the care that you receive now or in the future.

What would happen to you if you decided to take part?
Firstly, we would like to collect some basic information from you about your background and how the crime has affected you. We will use this information to help to understand the impact that crime has on people.
We will then check in about 3 months to see how you are. This will involve answering some short questions that should not take up more than 10 minutes of your time. In addition a small number of you will be asked to take part in a longer interview to tell us what has happened since the crime. People who remain distressed will be given the opportunity to take part in a talking therapy study.

What you have to do?
We recommend you read the helpful information given to you by the SNT and we will leave it up to you to act on it. Please stay in contact with us and let us know if you move or if you feel you need further information at this stage.

What are the possible disadvantages of taking part?
For most of you, the only inconvenience will be the time taken to complete some short questions, a smaller number will be asked for an hour or so of their time for in depth interviews.

What are the possible benefits of taking part?
Firstly, we would hope that providing you with information about the impact of crime and how to seek help would be useful. Secondly, monitoring your progress enables us to advise further, if necessary. Thirdly, other victims may be helped by the pool of information provided.

What if I have some concerns?
It is very unlikely that contacting you about the crime would worsen your distress. However, should you have any complaints about any aspect of the way you have been approached, the following options are available to you.

You could choose to approach any of the following: Firstly, the Chief Investigators team at UCL (Trefor Aspden; [redacted]; Division of Psychiatry, 6th Floor, 149 Tottenham Court Road, London, W1T 7NF). Secondly, the sponsors, UCL, (sponsor.priment@ucl.ac.uk, 0207 794 0500 ext 36724, PRIMENT, Upper 3rd Floor Royal Free, Rowland Hill Street, London, NW3 2PF). Thirdly, the funders, NIHR, PHR program (Room 132, 79 Whitehall, London, SW1A 2NS).

Would taking part in this be kept confidential?
Yes. All information collected about you would be kept strictly confidential in accordance with the Data Protection Act 1998. Any information will have your name and address removed and be given a special code number. This code number will also be used to identify any questionnaires which are sent, and the key to the code will be kept in a locked cabinet at the research center.

What happens to any results?
None of the people taking part would be identified in reports or publications. The results will be presented at conferences and published in relevant medical journals. Copies of publications would be made available at the end of the study from the organisers and sent to any participants who wish to have them.

Who is organising and funding the research?
This is organised by the University College Medical School, London. Funding has been organised through the National Institute of Health Research, Public Health Programme.

Contact for further information
This information sheet was prepared at the University College Medical School, 6th floor, Maple House, 149 Tottenham Court Road, London W1T 7NF. Please telephone the researcher on [redacted] if there is any further information you would like or if you have any questions you would like answered. They will take your number and 'phone you back.

Appendix 5.2. Consent Form- Step 1

VIP TRIAL Consent Form 1 Month Post Crime

POLICE
TOTAL POLICING

	Initials	Site	Subject
SCREENING ID	# #	# # # #	# # # #

Victim Improvement Package (VIP) Study
Helping Distressed Victims of Crime

	Please Initial Box	
1. I confirm that I have received the informtion sheet date(08/01/2018	YES	NO
2. I agree for my data to be used for the purpose of resea	YES	NO
3 3. I agree to my data being transferred t UCL, and archived for a period of 5 years following completion of the study	YES	NO
4. I understand that my data will be stored confidentially	YES	NO
5. I understand that I can withdraw from the study at any time	YES	NO
6. I agree to be contacted at three months for the above stu	YES	NO

The information provided will be held in the strictist of confidence and will not be shared outside the reseach team.

Forename:

Surname:

Address:

Post Code:

Landline

Mobile

Email

Signature **Date**

Appendix 5.3 Participant Information Sheet – Step 2

Victim Improvement Package Study:

Participant Information Step-2

We are inviting you to take part in a research study. It is important to read this information sheet first as it explains why the research is being done and what it will involve. Please do ask if there is anything that is not clear, or if you would like more information.

Purpose of the Research:
To examine the effects of crime on wellbeing, 3 months after the event, in people aged 65 years or more. To see whether the information provided by Safer Neighbourhood Teams (SNTs) has been helpful and useful. To provide victims who continue to be distressed with further information about the VIP study.

Why you have been chosen:
We are approaching you because the SNT felt you may have been distressed by the crime you suffered and you agreed to be approached by us to find out how you are doing.

Do I have to take part?
No it is up to you to decide whether or not to take part. Should you decline, please be assured that no further effort will be made to make you reconsider. Even if you do decide to take part you are still free to withdraw at any time and without giving a reason. Your decision will not affect the care that you receive now or in the future.

What does taking part involve?
We would like to arrange a time and place which is convenient for you to ask you some brief questions about how you are doing. We will ask a small number of you to take part in an in depth interview which will take about an hour. In this, we will ask you some questions about your thoughts and experiences of the information given to you by the SNT. This discussion will be tape recorded so that the researcher does not have to make notes during the session and can concentrate fully on listening to what you say.
As some of you may remain distressed, we will offer you the opportunity to discuss the possibility of taking part in the VIP study. Further information about this will be given in a separate sheet.

What if there is a problem?
We do not anticipate anybody to come to any harm by taking part in this study. However, information is included at the end of this sheet informing you about the process of dealing with any complaints or harm you feel you may have encountered in relation to the study.

Possible advantages of taking part
It is likely there will be no direct benefit to you for participating in this study; however we hope your views will help us to find out the best way of supporting older victims of crime in the future.

Possible disadvantages of taking part
A disadvantage of this study is that it will take a little of your time. There are no right or wrong answers to the questions we will ask you and you can talk about anything that you

feel is relevant. It is possible that during the interview you may find a topic sensitive or upsetting. If you do feel like this, please tell the researcher. You are free to ask the researcher to move on to another subject or stop the session altogether. You are not required to discuss anything that you do not want to.

What if there is a problem?
Every care will be taken during the course of this study. However, in the unlikely event that you are injured by taking part, compensation may be available. If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff or about any side effects you may have experienced due to your participation in the research you can speak to the Chief Investigator Dr Marc Serfaty on [redacted] who will do his best to answer your questions.

Confidentiality
All information that is collected about you during the course of the research will be kept strictly confidential. All audio-recordings will be stored securely and your name will not be with the recording. Notes will be taken from the recording but your name will be removed and it will not be possible for you to be identified from it. Only the research team will have access to the information. All data will be handled, processed, stored and destroyed in accordance with the Data Protection Act (1998).

Results of the research study
The results of the study will be published in scientific journals and at academic meetings. No one who takes part in this study will be able to be identified from any report or publication. If you would like a copy of the results, these will be available from Dr Marc Serfaty, UCL Division of Psychiatry, 6TH Floor, Maple House, 149 Tottenham Court Road, London, W1T 7NF.

Funding and review of the research study
This research is funded by the Department of Health. It has been approved by an Ethics Committee – University College London Research Ethics Committee.

What do I do now?
We will contact you by phone, letter or email to find out whether you are still agreeable to take part in this study

Thank you for your time reading this information sheet and for considering taking part in this study.

Appendix 5.4 Consent Form – Step 2

Consent to screening/qualitative work 3 months post crime.

Victim Improvement Package (VIP) study: helping distressed victims of crime

Chief Investigator: Dr Marc Serfaty

Site Reference: _ _ _

Personal Identification Number: _ _ _

	Please initial box
	yes
1. I confirm that I have read and understand the information sheet dated ……..for the above study. I have had the opportunity to ask questions and the researcher has explained the project and answered questions fully.	☐
	yes
2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected.	☐
	yes
3. I understand that any relevant personal/medical information, which may be collected during the study, will be made anonymous and added to that of others to form the results, which may be used in reports, publications or presentations.	☐
	Yes
4. I agree to take part in the above named study.	☐
Answering NO to the following will not exclude you from the VIP trial	Yes No
5. I consent to audio recordings of interviews to be used for research, quality control and analysis	☐ ☐
	Yes No
6. I agree to be contacted about future ethically approved research related to the VIP trial.	☐ ☐

…….	…….	…….
Name of person	Date	Signature
…….	…….	…….
Researcher	Date	Signature

Appendix 5.5 Participant Information Sheet – Qualitative Interviews

Victim Improvement Package Study:

Participant Information: Qualitative Interviews

We are inviting you to take part in a research study. It is important to read this information sheet first as it explains why the research is being done and what it will involve. Please do ask if there is anything that is not clear, or if you would like more information.

Purpose of the Research:
To explore the effects of crime on wellbeing, 3 months after the event, in people aged 65 years or more. To see whether the information provided by Safer Neighbourhood Teams (SNTs) has been helpful and useful. To explore how earlier experiences in victims' lives are involved in how they perceive the crime they have experienced.

Why you have been chosen:
We are approaching you because you previously completed a short questionnaire with a police SNT officer shortly after the crime, and you agreed to be contacted a few months later but a researcher from UCL to see how you are doing.

Do I have to take part?
No it is up to you to decide whether or not to take part. Should you decline, please be assured that no further effort will be made to make you reconsider. Even if you do decide to take part you are still free to withdraw at any time and without giving a reason. Your decision will not affect the care that you receive now or in the future.

What does taking part involve?
We would like to arrange a time and place which is convenient for you to complete an interview, which will take about an hour. During this interview, you will be asked some questions about what it was like for you when you were growing up, and some questions about the crime and how it has impacted you. You will also be asked about your thoughts on the information given to you by the SNT, and what your experiences of services related to the crime have been like. This discussion will be tape recorded so that the researcher does not have to make notes during the session and can concentrate fully on listening to what you say.

What if there is a problem?
We do not anticipate anybody to come to any harm by taking part in this study. However, information is included at the end of this sheet informing you about the process of dealing with any complaints or harm you feel you may have encountered in relation to the study.

Possible advantages of taking part
It is likely there will be no direct benefit to you for participating in this study; however we hope your views will help us to find out the best way of supporting older victims of crime in the future.

Possible disadvantages of taking part
A disadvantage of this study is that it will take some of your time. There are no right or wrong answers to the questions we will ask you and you can talk about anything that you feel is

relevant. It is possible that during the interview you may find a topic sensitive or upsetting. If you do feel like this, please tell the researcher. You are free to ask the researcher to move on to another subject or stop the session altogether. You are not required to discuss anything that you do not want to.

What if there is a problem?
Every care will be taken during the course of this study. However, in the unlikely event that you are injured by taking part, compensation may be available. If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff or about any side effects you may have experienced due to your participation in the research you can speak to the Chief Investigator Dr Marc Serfaty on [redacted] who will do his best to answer your questions.

Confidentiality
All information that is collected about you during the course of the research will be kept strictly confidential. All audio-recordings will be stored securely and your name will not be with the recording. Notes will be taken from the recording but your name will be removed and it will not be possible for you to be identified from it. Only the research team will have access to the information. All data will be handled, processed, stored and destroyed in accordance with the Data Protection Act (1998).

Results of the research study
The results of the study will be published in scientific journals and at academic meetings. No one who takes part in this study will be able to be identified from any report or publication. If you would like a copy of the results, these will be available from Dr Marc Serfaty, UCL Division of Psychiatry, 6TH Floor, Maple House, 149 Tottenham Court Road, London, W1T 7NF.

Funding and review of the research study
This research is funded by the Department of Health. It has been approved by an Ethics Committee – University College London Research Ethics Committee.

What do I do now?
We will contact you by phone, letter or email to find out whether you are still agreeable to take part in this study

Thank you for your time reading this information sheet and for considering taking part in this study.

Appendix 5.6 Consent Form - Qualitative Interviews

Consent to qualitative work post crime.

Victim Improvement Package (VIP) study: helping distressed victims of crime

Chief Investigator: Dr Marc Serfaty
Site Reference: _ _ _

Personal Identification Number: _ _ _	Please initial box
	yes
1. I confirm that I have read and understand the information sheet dated ……..for the above study. I have had the opportunity to ask questions and the researcher has explained the project and answered questions fully.	☐
	yes
2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected.	☐
	yes
3. I understand that any relevant personal/medical information, which may be collected during the study, will be made anonymous and added to that of others to form the results, which may be used in reports, publications or presentations.	☐
	Yes
4. I consent to audio recordings of interviews to be used for research, quality control and analysis	☐
5. I agree to take part in the above named study.	☐
Answering NO to the following will not exclude you from the VIP qualitative interviews	Yes / No
6. I agree to be contacted about future ethically approved research related to the VIP trial.	☐ / ☐

…….	…….	…….
Name of person	Date	Signature
…….	…….	…….
Researcher	Date	Signature

Appendix 5.7 Participant Information Sheet – Step 3

Participant Information sheet
- Step 3
Victim Improvement Package (VIP) study: helping distressed victims of crime.

THIS INFORMATION SHEET IS TO ASK YOU WHETHER YOU WOULD TAKE PART IN A STUDY AND WHAT THIS WOULD INVOLVE.

We are sorry to hear that you are still distressed by the crime and would like to offer you, if appropriate, the opportunity to take part in a study to see whether or not a supportive therapy, called a Victim Improvement Package (VIP), helps.

Who are we and what would this study be about? This study is organised by the University College Medical School, London. Funding has been provided by the National Institute of Health Research, Public Health Programme. We are experts from the School of Medicine (UCL), the Jill Dando Institute of Crime Science, the Metropolitan Police (Met), Mind counselling service and Age UK.

Why have you been chosen? We are approaching victims aged 65 years or more who may be significantly distressed at 3 months after the crime to see if our intervention helps.

What will the study involve?: A researcher will meet with you, at a time and place convenient for you, and ask you some standard questions regarding the impact of crime. This may take up to an hour. If appropriate, half of you will be offered a Victim Improvement Package which will consist of up to 10 weekly sessions of an hour with a trained therapist, delivered over 3 months. This is in addition to any currently available care deemed necessary by GPs or other professionals which everyone can receive. The allocation to VIP will be done by a process known as randomisation (described below). All sessions will be recorded for quality control and for research. A cognitive behaviour therapy (CBT) approach is used in the VIP. This helps people develop new ways of thinking and coping. As part of good practice, we would also prefer to notify your GP that you are involved, but this is not absolutely necessary.

How long will the study last?: We need to review your progress for at least up to 9 months after the crime (about 6 months from now). This will be done by asking you some questions now and then only twice in the next 6 months, either in person with the researcher or on the phone, whichever is more convenient. A*lthough not necessary in order to take part in the trial, if agreeable we would like to approach people again at two years after the crime to see how they are managing*.

What is the randomisation process?: The allocation to which treatment you receive is performed by computer. You will have an equal chance of being allocated to usual care or usual care plus the VIP.

Do you have to take part? No it is up to you to decide whether or not to take part. Should you decline, please be assured that no further effort will be made to make you reconsider. Even if you do decide to take part you are still free to withdraw at any time and without giving a reason. Your decision will not affect the care that you receive now or in the future.

What you have to do?: Read through the information and give yourself at least 48 hours to consider whether you are interested. Feel free to discuss it with a friend or relative. Depending on your choice, we will arrange a more detailed interview, to see if you we can help and if suitable, obtain your consent to take part.

What are the possible disadvantages of taking part?: The main inconvenience will be the time taken to complete questionnaires. This may last up to an hour on 3 separate occasions over 6 months. For those receiving the VIP, you will also be expected to attend up to 10 sessions, each of an hour weekly, spread out over 3 months. Some of you may be disappointed by not having the treatment you wish. The therapists are trained to manage talking about past events, which can be difficult, but it is unlikely that this is harmful. Some of you may be assessed in your home, if you wish. The intervention will be given at a local therapy centre and travel expenses offered.

What are the possible benefits of taking part? Firstly, you will be monitored for distress and given information about how to access services. Secondly, receiving the VIP, or care from your GP, may help. Thirdly, your involvement will assist us to develop the best ways to manage victims of crime.

What if something went wrong? It is unlikely that you could be harmed by taking part in a study of this nature, but we need to tell you what procedures may be available to you, should you have complaints. If you wish to complain about any aspect of the way you have been approached or treated during the course of this study, you could chose to approach any of the following: The Chief Investigator team at UCL (Trefor Aspden; [redacted] Division of Psychiatry, 6th Floor, 149 Tottenham Court Road, London, W1T 7NF). 2 The sponsors, UCL, (sponsor.priment@ucl.ac.uk, 0207 794 0500 ext 36724, PRIMENT, Upper 3rd Floor Royal Free, Rowland Hill Street, London, NW3 2PF). 3. The funders, NIHR, PHR programme (Room 132, 79 Whitehall, London, SW1A 2NS), where there is no suggestion of negligence. The study is covered by insurance for negligent harm. If there is a concern about personal negligence, you may have grounds for legal action, but may have to pay for this.

Would taking part in this study be kept confidential? All information collected during the research will be kept strictly confidential. All tape-recordings will be stored securely and your name will not be with the recording. Notes will be taken from the recording, but your name will be removed and it will not be possible for you to be identified from it. Only the research team will have access to data, which will be handled, processed, stored and destroyed in accordance with the Data Protection Act (1998).

What happens to the results of the study? The results will be published in scientific journals and at academic meetings. No one who takes part in this study will be identifiable from any report or publication. If you would like a copy of the results, these will be available from Dr Marc Serfaty, 6TH Floor, Maple House, 149 Tottenham Court Road, London, W1T 7NF.

Contact for further information This information sheet was prepared at the University College Medical School, 6th floor, Maple House, 149 Tottenham Court Road, London W1T 7NF. Please telephone the researcher on [redacted] if there is any further information you would like or if you have any questions you would like answered. They will take your number and phone you back.

Appendix 5.8 Consent Form – Step 3

Consent 3 months post crime.

Victim Improvement Package (VIP) study: helping distressed victims of crime

Chief Investigator: Dr Marc Serfaty
Site Reference: _ _ _
Personal Identification Number: _ _ _

	Please initial box Yes
1. I confirm that I have read and understand the information sheet dated .....for the above study. I have had the opportunity to ask questions and the researcher has explained the project and answered questions fully.	☐
2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected.	☐
3. I agree to be randomly allocated to either Treatment as Usual (TAU) or TAU plus the VIP.	☐
4. I understand that any relevant personal/medical information, which may be collected during the study, will be made anonymous and added to that of others to form the results, which may be used in reports, publications or presentations.	☐
5. I agree to take part in the above named study.	☐
Answering NO to the following will not exclude you from the VIP trial	
	Yes / No
6. I consent to audio recordings of therapy sessions to be used for research, quality control and analysis.	☐ ☐
7. I consent to measures of distress and information about coping methods used to manage my distress, obtained during therapy, being shared with the trial for research purposes.	☐ ☐

..... Name of person	..... Date	..... Signature
..... Researcher	..... Date	..... Signature

Appendix 6: Systematic Review Materials

Appendix 6.1: PRISMA Checklist

Section and Topic	Item #	Checklist item	Page number where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	58
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	3, 59
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	55,56-57,59
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	59
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	59-60
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	60-61
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	60-61
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	61
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	61
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	61
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	61
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	61

Section and Topic	Item #	Checklist item	Page number where item is reported
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	n/a
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	61-62
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	61
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	61
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	62
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	n/a
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	n/a
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	n/a
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	61
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	63-64
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Appendix 5
Study characteristics	17	Cite each included study and present its characteristics.	67-69
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	65, Appendix 5
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	79-87, 91-92
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	70-87
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	n/a
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	n/a

Section and Topic	Item #	Checklist item	Page number where item is reported
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	n/a
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	n/a
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	n/a
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	93-96
	23b	Discuss any limitations of the evidence included in the review.	96-97
	23c	Discuss any limitations of the review processes used.	97
	23d	Discuss implications of the results for practice, policy, and future research.	94, 97
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	59
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	59
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	59
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	Appendix 7
Competing interests	26	Declare any competing interests of review authors.	N/A
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Appendix 5

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

Appendix 6.2. Search Strategy

Search Strategy

older adult* OR older people OR older victim* OR older complainant OR aged OR elderly OR pensioner* OR senior citizen*

AND

crime* OR felon* OR misdemeanour* OR assault OR theft OR fraud OR robbery OR burglary OR violen* OR interpersonal violen* OR rape OR scam* OR arson OR criminal damage OR distraction burglary OR stalking OR harassment OR phishing OR cyber-crime OR cybercrime OR cyber crime

AND

wellbeing OR anx* OR depress* or traum* OR distress OR psychological impact OR mental health outcome* OR psychiatric outcome* OR psychological outcome* OR psychological symptom* OR psychiatric symptom*

Original Screening 01.08.2019

Embase 1980-2019 Week 30 - 6207
Ovid MEDLINE(R) 1946 to July Week 4 2019 (with 1980 & English language filter) – 6491
PsycINFO 1806 to July Week 2 2019 (with 1980 & English language filter) – 3101
PILOT (1st Jan 1980 to 1st Aug 2019 & English language filter) – 702
CINAHL (Jan 1980 to Aug 2019 & English language filter) – 1675

Total references: 18,176
Total references after duplicates removed from endnote: 12,347.
Total references after duplicates removed from Rayyan: 10,928

Updated Screening 31.08.2021

Embase (1980-2021 week 34) (limit 1 to (dc=20190801-20210831) (01.08.2019-31.08.2021)(limit 2 to English language) = 484
Ovid MEDLINE(R) (1946 to August week 3 2021) (limit 1 to (English language yr= "1980-current") (limit 2 to (dt=20190831-20210831)) (01.08.2019-31.08.2021) = 176
APA PsycINFO (1806- to July week 2 2019) (with 1980 & English language filter) (with limit 2019 – August week 4 2021) = 209
PTSDPubs (renamed from PILOTS) (from 1st August 2019 – 31st August 2021) = 129
CINAHL (published date 2019-08-01 to 2021 -08-31; English language) = 3
Total references: 1,001
Total references after duplicates removed from EndNote: 812
Total references after duplicates removed from Rayyan: 691

Cochrane Central Register of Controlled Trials (CENTRAL)

Keyword search on 25.10.2021:
"older victim" – 101 trials matching keyword search – 0 additional studies not identified in previous searches found.

(NB: The VIP trial protocol paper (Serfaty et al., 2020) otherwise meets criteria but no primary data yet available).

ISRCTN Registry
Keyword search on 25.10.2021
"older victim" – 5 results – 0 additional studies not identified in previous searches found.
"crime victim" – 8 results – 0 additional studies not identified in previous search found.

Updated screening 19.04.2022

Embase (1980-2022 week 15) (limit 2 to (English language and yr="2021-current") = 340
Ovid MEDLINE (R) (1946 – April week 2 2022) (limit 2 to (English language and yr="2021-Current") = 201
APA PsycInfo (1806 – April week 2 2022) (limit 1 to (English language and yr='2021-current) = 60
PTSDPubs (Date: From September 01 2021 to April 19 2022; Source type: Journal Article; Language: English) = 2
CINAHL (Published Date: 20210901-20220431; English Language; Peer Reviewed) = 76
Total = 679
Total references after duplicates removed from EndNote: = 398
Total references after duplicates removed from Rayyan = 361
Excluded based on titles and abstracts = 351
Full text review = 10
Included = 1

Cochrane Central Register of Controlled Trials (CENTRAL)
Keyword search on 21.04.2022
"older victim" – 68 results returned – 0 new studies found
"crime victim" – 33 results returned – 0 new studies found

ISRCTN Registry
Keyword search on 21.04.2022
"older victim" – 6 results – 0 new studies found.
"crime victim" – 8 results – 0 new studies found.

Updated screening 26.10.2023

Embase (limit 2 to (English language and yr="2022-current")
Ovid MEDLINE (R) (1946 – April week 2 2022) (limit 2 to (English language and yr="2022-Current")
APA PsycInfo (1806 – April week 2 2022) (limit 1 to (English language and yr='2022-current)
PTSDPubs (Date: From January 01 2022 to October 26th 2023; Source type: Journal Article; Language: English)
CINAHL (Published Date: 01-01-22-26-10-2023; English Language; Peer Reviewed)
Total = 3,546

Total references after duplicates removed from EndNote and Rayyan: = 2,960
Excluded based on titles and abstracts = 2,928
Full text review = 29
Included = 3

Cochrane Central Register of Controlled Trials (CENTRAL)
Keyword search on 02.11.2023
"older victim" – 5 results returned – 0 new studies found
"crime victim" – 6 results returned – 0 new studies found

ISRCTN Registry
Keyword search on 02.11.2023
"older victim" – 7 results – 0 new studies found.
"crime victim" – 12 results – 0 new studies found.

Appendix 6.3. Second Stage Decision Log – Full Text Papers Checked

1	(O'Neill et al., 1989)	Included	Burglary survey of older inpatients in hospital in Ireland
2	(Steve Simpson et al., 1996)	Included	Old Age Psychiatry Community Clinic in Manchester. Assessed PTSD in those who reported having been victims of crime. Case studies indicated burglary / stranger perpetrated assault.
3	(Marc Serfaty et al., 2016)	Included	Psychological impact of common crime in older victims / pilot RCT.
4	(M. J. Gray & R. E. Acierno, 2002)	Excluded	**Wrong exposure/Domestic violence:** "Domestic violence was the modal crime (40%)"
5	(Acierno et al., 2002)	Excluded	**Wrong/ exposure/ Domestic violence:** Questionnaire to measure crime states: "Has anyone – including family members or friends – ever attacked you…" Sample breakdown not provided.
6	(Acierno et al., 2007)	Excluded	**Wrong exposure /Domestic violence:** Questionnaire to measure crime states: "Has anyone – including family members or friends – ever attacked you…" Sample breakdown not provided.
7	(Kazantzis et al., 2010)	Excluded	**Wrong population / age:** Psychological impact of crime not provided by age. Psychological impact of stranger perpetrated and domestic crimes not clearly stated
8	(Brunet et al., 2013)	Included	Does not specify DV anywhere, although it does say that 80% victims of an aggressor were female – email sent 23.08.2021 requesting clarification, no response received.
9	(Cook et al., 2013)	Excluded	**Wrong exposure / DV:** "Physical assault included 'beaten up before age 18, beaten up by spouse / romantic partner and / or being beaten up by someone else" "sexual assault included being 'sexually assaulted as an adult or child" Numbers of older victims 'assaulted by someone else' provided separately but psychological impact not provided on this basis.
10	(Fredriksen-Goldsen et al., 2014)	Included	Study on risk and protective factors in transgender older adults. Includes victimisation as one such factor. No reference to DV but does not state it as exclusion criteria it either.
11	(Sachs-Ericsson et al., 2014)	Excluded	**Wrong exposure/DV: "**Victim's spouse or romantic partner accounted for the highest percentage of perpetrators" "We also examined the type of perpetrator in relation to the number of health problems. There was no differences by perpetrator status".
12	(Reisig et al., 2017)	Included	Older victims of theft, consumer fraud and physical assault. DV not mentioned although not explicitly stated as an exclusion criteria either.
13	(Qin & Yan, 2018)	Included	Mental health impact / constrained behaviour in older victims of common crime in urban China. Domestic violence and common crime analysed and presented separately
14	(Acierno et al., 2004b)	Included with protocol amendment	Preliminary video RCT for older crime victims. Physical assault, theft, verbal abuse. (DV 7.5% of men, 13.2% females so minority of crimes)
15	(McGraw & Drennan, 2006)	Included	Descriptive intervention for older victims of distraction burglary
16	(Spalek, 1999)	Included	Qualitative – older victims of fraud
17	(Cross, 2015)	Included	Qualitative – older victims of fraud
18	(Tripathi et al., 2019)	Included	Qualitative – older males of cyber-crime
19	(Tan & Haining, 2016)	Included	Separate age analysis presented Crimes were burglary, vehicle-related theft, theft of credit card, other forms of theft, vandalism, threatening abusive behaviour, violent assault, robbery / mugging
20	(Kazantzis et al., 2010)	Excluded	**Wrong exposure / DV:** Crime (sexual assault, theft by force, domestic assault, other physical assault)

			Separate age analysis provided but not separated from DV
21	(Norris, 1992a)	Included	Robbery, physical assault, sexual assault. No mention of DV. Analysis presented by age
22	(Zinzow et al., 2010)	Excluded	**Wrong population / age/DV:** Age breakdown provided and breakdown whether known perpetrator or not but no analysis for older age group with unknown perpetrator.
23	(Iganski & Lagou, 2015)	Included	Hate crime data from British Crime Survey. Age breakdown provided.
24	(Blay et al., 2018)	Excluded	**Wrong exposure / neighbourhood violence:** Neighbourhood violence rather than direct Age breakdown provided
25	(Mawby, 1982)	Excluded	**No data** Review paper – fear of crime / victim's paradox
26	(Cook et al., 2011)	Excluded	**No data** Review paper
27	(Amstadter et al., 2008)	Excluded	**Wrong outcome** Paper on help-seeking, not psychological outcomes.
28	(Arboleda-Flo´reza & Wade, 2001)	Excluded	**Wrong population/ age:** Wrong age group
29	(Beaulieu et al., 2007)	Excluded	**Wrong population/ fear of crime:** The study is on fear of crime
30	(D'Haese et al., 2015)	Excluded	**Wrong population / age:** Lower age limit below 50
31	(Kilpatrick et al., 1985)	Excluded	**Wrong population / non-victims:** Paper focuses on mental health of crime victims, including older adults. However, the data for older adults is presented 'irrespective of victim status' and separate 'older victim' data is not provided.
32	(Padmanabhanunni & Edwards, 2016)	Excluded	**Wrong population / age:** Low age limit below 50. One case study of someone aged over 50 but reported IPV
33	(Ganzini et al., 1990)	Excluded	**No data:** Discussion / review paper. Does not appear to provide primary data.
34	(Bowland, 2015)	Excluded	**Wrong exposure / DV/child abuse:** Qualitative study of older African-American trauma survivors in mixed housing. Eligible crimes included but alongside IPV and child abuse. Does not appear to include any participants who suffered eligible crimes but not also childhood abuse / DV
35	(Tyra, 1993)	Excluded	**No data:** Review / discussion paper. No primary data.
36	(Lichtenberg Pa Ph.D et al., 2019)	Excluded	**Wrong intervention / not psychological:** Intervention paper for older victims of financial exploitation but focus on debt recovery and preventing future scams, not a psychological intervention.
37	(Burgess & Morgenbesser, 2005)	Excluded	**No data:** Review paper, no primary data.
38	(Krause, 1986)	Included	Study of social support on mental health outcomes after stressful events in older adults, analysis specifically on crime presented.
39	(Hirschel & Rubin, 1982)	Excluded	**No data:** Review / discussion paper, no primary data
40	(Jones, 1987)	Included	Mostly case study data. Data is based on complaints to warden but they are described as living alone and in the community.
41	(Aliche & Onyishi, 2019)	Excluded	**Wrong population/ age:** Sent to adjudicator as paper intended for older adults but lower age limit due to reduced life expectancy in Nigeria. Adjudicator view was that protocol is clear that papers with lower age limit below 50 should be excluded.
42	(Grimes et al., 1990)	Excluded	**Wrong exposure / neighbourhood crime:** Impact of neighbourhood crime rather than direct victims.
43	(Tyra, 1996)	Included	Mostly review discussion paper, but one case study describing psychological impact so this aspect meets criteria. No data provided on intervention.
44	(Bailey et al., 2020)	Included	Subjective impact of older victims of scams

45	(Muhammad et al., 2021a)	Included	Looked at association of violent crime and major depression in older adults in India. Although this study also looked at elder abuse, which is an exclusion criteria, the data on crime victimhood was clearly analysed and reported separately.
46	(Nobels et al., 2022a)	Excluded	Only conference abstract available so does not meet peer-reviewed journal criteria. The study may include data relevant for the review but the focus was on abuse in childhood in the abstract so this could not be clearly reported on in the systematic review.
47	(Baranyi et al., 2022)	Excluded	Neighbourhood crime not direct experience of crime.
48	(Breedt & Steyn, 2022)	Excluded	Focus in on injury from falling
49	(Chandra, 2021)	Excluded	Only conference abstract available so does not meet peer-reviewed journal criteria. There is reference to crime but this appears to be referring to domestic violence, which is excluded.
50	(Dayman, 2021)	Excluded	Only conference abstract available so does not meet peer-reviewed journal criteria. This also appears to be referring to forensic characteristics so psychological impact does not appear to be discussed.
51	(DeMello et al., 2020)	Excluded	Domestic violence.
52	(Pengpid & Peltzer, 2022)	Excluded	Similar to Muhammad et al (2021) study and used the same dataset but did not report crime specifically for the older adult age group.
53	(Yu et al., 2021)	Excluded	Assessed susceptibility to scams and psychological wellbeing but did not appear to assess this in people who had been victims of scams.
54	(Yu & Liu, 2021)	Excluded	Although this study looked at depression of stressful events including fraud, it did not report fraud separately from other stressful events (e.g., bereavement).
55	Holtzer, AbiNader, Vaughn & Salas-Wright, 2022)	Excluded	**Wrong population:** The paper is titled 'Crime and Violence in Older Adults' but it is referring to older offenders, not victims.
56	(Brooks et al., 2022)	Excluded	**Wrong population:** The prevalence of community crimes are reported but the impact is reported as 'any assaultive violence' so includes domestic violence in its reporting.
57	(Cook et al., 2023)	Excluded	**Wrong population:** Does not distinguish between community crimes and domestic violence
58	(Eshelman et al., 2022)	Excluded	**Wrong population:** Younger victims
59	(Gammage et al., 2022)	Excluded	**Wrong population:** Younger victims
60	(Ginzburg et al., 2022)	Excluded	**Wrong population:** Neighbourhood crime
61	(Golovchanova et al., 2023)	Excluded	**Wrong population:** Neighbourhood crime / fear of crime rather than on victims
62	(Hahn et al., 2023)	Excluded	**No data:** Trial protocol – the data has not yet been published.
63	(Ishimaru et al., 2022)	Excluded	**Wrong outcome:** Does not report on psychological impact
64	(Johansen et al., 2022)	Excluded	**Wrong population:** Younger victims
65	(Li et al., 2023)	Excluded	**No data:** Conference abstract
66	(Mark et al., 2023)	Excluded	**Wrong population:** Younger victims
67	(Mohd Mokhtar et al., 2022)	Excluded	**Wrong population:** Although older adults, crime and psychological impact are all separately discussed, there is no data on these three factors together.
68	(Mrejen et al., 2023)	Excluded	**Wrong outcome:** Proportion of violence was broken down by age but not psychological impact
69	(Nobels et al., 2022b)	Excluded	**Wrong population:** Does not distinguish between carer abuse and community crime
70	(Brown et al., 2019)	Excluded	**No data:** Protocol, younger victims
71	(Pearson et al., 2023)	Excluded	**Wrong population:** Younger victims
72	(Roebuck et al., 2023)	Excluded	**Wrong outcome:** Psychological impact not broken down by age
73	(Rostaminejad et al., 2022)	Excluded	**Wrong population:** Younger victims

74	(Sampson et al., 2022)	Excluded	**Wrong population:** Trauma type / psychological impact not broken down by age
75	(Schnittker, 2022)	Excluded	**Wrong population:** Younger victims
76	(Serpeloni et al., 2023)	Excluded	**Wrong population:** Although community violence was eligible, most were domestic crimes and a breakdown of crime types for older participants was not provided
77	(Stensvehagen et al., 2023)	Excluded	**Wrong population:** Younger victims
78	(Stewart et al., 2022)	Excluded	**Wrong population:** Domestic violence
79	(Storey et al., 2023)	Excluded	**Wrong population:** Younger victims
80	(Winiker et al., 2023)	Excluded	**Wrong outcome:** Although an older adult of community violence was included, they described the assault but not the psychological impact of it.
81	(Gibson et al., 2020)	Included	Psychological impact in older adults after workplace harassment
82	(Goldblatt et al., 2022)	Included	Qualitative study on service barriers after sexual assault but includes brief description of psychological impact in older victims
83	(Kemp & Erades Perez, 2023)	Included	Paper on cybercrime that includes a brief discussion of psychological impact in older victims

Dear Vari,

RE: Distress in Older Victims of Common Crime: A Systematic Review

Thank you for kindly agreeing to be adjudicator for the above systematic review.

Screening is nearly complete. The search strategy identified 10, 946 papers. 100% of results have been screened by two raters (working version of PRISMA flow chart attached). The second screener and I agreed on 99.8% of papers with inter-rater reliability of 0.66 (95% CI: 0.52- 0.79; 'substantial agreement' (Cohen, 1960)). 63 results were resolved through discussion but as adjudicator we would appreciate your judgement on the final few:

1. Onyishi & Aliche (2019): older victims in Nigeria defined as aged 45+. The age range in our protocol is 50+, however, the age range for this study has been lowered in recognition of reduced life expectancy in Nigeria. It is still a paper on 'older victims' but against protocol.

2. Lichtenberg, Hall & Campbell (2019): intervention more psychosocial than therapeutic. Authors state they look at financial crime on mental health outcomes but in practice appear to instead look at mental health as a vulnerability factor to financial crime and financial health as the outcome.

3. A handful of studies have included and reported on older adults, crime and mental health in regression models alongside other age groups, traumatic events and outcomes. Data is presented on our area of interest but the examination is cursory rather than the full focus of the paper. Should these papers be included and quality appraised?

I have attached the two cited studies and the Prospero protocol for reference.

I recognise this is a very busy time of year so if we don't get a chance to speak before, have a wonderful Christmas and I look forward to hearing from you in the new year.

Best wishes,

Jess

Judgement sought from adjudicator for systematic review

DM

Drennan, Vari M [redacted]

Sat 18/01/2020 07:11

To: Satchell, Jessica

Cc: Craston, Tabs; Serfaty, Marc

Dear Jessica ,

My view

Exclude Lichtenberg, Hall & Campbell (2019) . This is not a psychological intervention (our protocol). The intervention is Four-part financial literacy series, Free one-on-one services to address financial impacts of scams and identity theft.

Exclude Onyishi & Aliche as it includes people under 50+ and does not present data for over 50 seperately . Our protocol is clear on any age for any country .

Re handful of studies
If there is data that meets the inclusion criteria it should be included. Our protocol did not specify exclusion.

I hope this is helpful .

Sorry for the delay
Bw
Vari

Appendix 6.4 Mixed-Methods Appraisal Tool (MMAT) (Hong et al., 2018)

Category of study designs	**Methodological quality criteria** (✓) = yes, (X) = no, (?) = not clearly reported	Spalek (1999)	Cross (2015)	Tripathi, Robertson & Copper (2019)	Bailey, Taylor, Kingston & Watts (2020)	Acierno et al., (2004)	Serfaty et al., (2016)	McGraw & Drennan	Tyra (1996)	Krause (1986)	Jones (1987)	O' Neill et al., (1989)	Norris (1992)	Simpson, Morley & Baldwin (1996)	Brunet et al., (2013)	Fredriksen-Goldsen et al., (2014)	Iganski & Laugou (2015)	Tan & Haining (2016)	Resig, Holtfreter & Turanovic (2017)	Qin & Yang (2018)	Muhammed et al., (2021)	Kemp & Erades Perez (2023)
Screening questions (for all types)	S1. Are there clear research questions?	✓	✓	✓	X	✓	✓	X	X	✓	X	✓	✓	✓	✓	✓	X	X	✓	✓	✓	✓
	S2. Do collected data allow to address the research questions?	✓	✓	✓	X	✓	✓	X	X	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	✓	✓	✓	X																	
	1.2. Are the qualitative data collection	✓	✓	✓	X																	

	methods adequate to address the research question?																					
	1.3 Are the findings adequately derived from the data?	?	✓	?	X																	
	1.4 Is the interpretation of results sufficiently substantiated by data?	?	✓	✓	X																	
	1.5. Is there coherence between qualitative data sources, collection, analysis, and interpretation?	?	✓	?	X																	
2. Quantitative randomised controlled trials	2.1 Is randomisation appropriately performed?					?	✓															
	2.3 Are the groups comparable at baseline?					?	?															
	2.4 Are there complete outcome data?					X	✓															
	2.5 Are outcome assessors blinded to the intervention provided?					X	✓															
	2.6 Did the participant adhere to the assigned intervention?					✓	✓															
3. Quantitative	3.1 Are the participants							?	X													

non-randomised	representative of the target population?																						
	3.2. Are the measurements appropriate regarding both the outcome and intervention (or exposure)?							✓	X														
	3.3. Are there complete outcome data?							X	X														
	3.4. Are the cofounders accounted for in the design and analysis?							X	X														
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?							✓	X														
4. Quantitative descriptive	4.1 Is the sampling strategy relevant to address the research question?									X	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	4.2 Is the sample representative of the target population?									X	X	X	X	X	X	?	✓	✓	✓	X	✓	✓	
	4.3. Are the measurements appropriate?									X	X	X	✓	X	✓	✓	X	X	X	X	✓	X	
	4.4. Is the risk of nonresponse bias low?									X	?	X	X	X	X	X	X	X	X	X	✓	✓	

	4.5 Is the statistical analysis appropriate to answer the research question?									✓	X	X	✓	✓	✓	✓	X	X	✓	X	✓	✓
5. Mixed Methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?																					
	5.2. Are the different components of the study effectively integrated to answer the research question?																					
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?																					
	5.4 Are the divergences and inconsistencies between quantitative and qualitative results adequately interpreted?																					
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?																					

Appendix 7: Qualitative Study Materials

Appendix 7.1: Topic Guide for Qualitative Interviews

Background information:

The interviews will be semi-structured and participants will be encouraged to develop a narrative of events as much as possible. The topic guide features 5 main areas of enquiry which have been broadly organised into before the crime, the crime itself and after the crime:

1. Their background / how they would describe their lives including any adversity they have experienced previously
2. Their response to the crime (their interpretation, any changes in behaviour)
3. Their earlier life experiences and their interpretation of the crime
4. The help that they've received and their experiences of it
5. The letter for their GP given to them by the police safer neighbourhood team and their experiences of this

Topic guide:

(*Introduction - purpose of the study, consent form, rapport building*)

Turn tape recorder on:

1. Their background and previous experiences

QA. "To start with, where abouts did you grow up?"

QB. "What was it like growing up?"

Subsidiary questions:

Where did you grow up? Who was in your family? What was a typical day in your childhood like, how would you describe it? What was your relationship with your family like? What was your neighbourhood like? How safe did you feel growing up? What was that like for you?

If an overly one-sided view is presented: Were there any worse times / were there any better times?

QC. (*If not already discussed by the interviewee*): **"When you were growing up or as an adult, have you experienced any major life events or changes, or have you ever experienced anything particularly traumatic?"**

Subsidiary questions-

Have you been a victim of crime before?

Probe outside of family life as well within the family

2. The crime itself:

QA. "Can you cast your mind back to the day the crime happened and tell me what you remember about that day"? *If participant is very talkative, the question may need to be re-phrased as 'can you briefly tell me about the crime? About what happened?'*

Subsidiary questions –

What was the day like? What had you been doing that day? Can you describe the crime / can you describe how you became aware that a crime had taken place?" Was anyone else there?

QB. "How did you respond? Tell me about what happened in the hours and days after the crime"

Subsidiary questions –

-What went through you mind at that time?

- How did you feel? What did you do?
- Who did they tell/who knew?
- Did they ask anyone for advice/help/support?
- Can they remember if they were anxious/angry/depressed?

QC. "Sometimes people who have been victims of crime blame themselves for what happened, even if it wasn't their fault. Have you experienced any feelings like that? What has that been like for you?"

Subsidiary questions -

What thoughts have gone through your mind?

How do you think other people perceive what happened?

3. The aftermath of the crime:

QA. "How have you coped in the weeks and months since the crime?"

Subsidiary questions –

How have you felt? What thoughts or feelings have you had about what happened? Has the crime impacted on your day-to-day to life at all and, if so, how? What sort of things have you done to help you cope? Have you noticed any changes in your behaviour since then? What differences does (*e.g. not going out at night)* make?

QB. [Link back to some of the points they made, echoing the language that they've used] "**What do you think it is about yourself that means that you've responded in this way?"**

Subsidiary questions -

Is there anything about your earlier experiences that you think may have influenced your reaction to what happened?

E.g. You mentioned earlier that you did not have many belongings when you were growing up, is that connected at all to the feelings of anger you're describing at being burgled, do you think? Can you tell me more about that?

"Are there any other experiences you've had during your childhood or adult life that you think may be related to how you are feeling now?"

4. Leading on to help and support they've received (if any):

QA. "What help or support, if any, have you received or been offered since the crime happened?"

Probe formal help – e.g. police, victim support etc.

Probe informal help – friends, family, neighbours, pastoral / spiritual support etc.

Subsidiary questions –

- What did they say or do?

- How did this come about? Did you approach them or did they approach you?

- *If they approached a service* – why did you decide to contact them? (*probe whether they sought support of their own volition or were encouraged to do so by others)*

QB. *Linking back to the service(s) mentioned* - **"What was your experience of [that service] like?"**

Subsidiary questions:

- What did you think about what they said or did? How did you feel about it? Was there anything you would have like them to have done differently?

QC. What other support or help do you think you would have found useful or do you think other victims of crime might find useful?

QD. What sort of things do you think would make other victims of crime more or less likely to seek help from services?

5. The letter for their GP:

QA. "When the police visited you before, they gave you an information pack. In that pack was a letter which you could take to your GP, do you remember receiving that letter?"

If they do remember receiving the letter:

- Did you read the letter? What did you think about it?
- What did you do with it?
- Why did or didn't you decide to take the letter to your GP?

If they took their letter to their GP:

- How did the doctor respond?

- How did you think they were going to respond?

- How would you have liked them to have responded? Is there anything you would have liked them to have done differently?

If they do not remember receiving the letter:

- What do you think about the idea of a letter like that?

- What do you think you might have done with the letter if you had been aware of it?

- How do you think a doctor would be likely to respond if you gave them a letter like that? What do you think you might do?

Conclusion – is there anything else you'd like to mention or discuss that has not yet been covered

Thank them for their time and ask whether they would like to ask me any questions.

Appendix 7.2 Table: Psychological and Behavioural Impacts

Impacts observed in my systematic review of the existing literature				
1. Upset	7. Poor sleep	13. Post-traumatic stress disorder	19. Depression	25. Flashbacks
2. Frightened	8. Intrusive thoughts	14. Fear of further crime	20. Reduced self-esteem	26. Stress
3. Disbelief	9. Feeling vulnerable	15. Fear of going out / agoraphobia	21. Loss of trust / mistrust	27. Panic attacks
4. Crying	10. Insecurity	16. Fear of staying alone	22. Loss of confidence	28. Self-blame
5. Embarrassment	11. Anger	17. Impaired concentration	23. Shame	29. Shock
6. Fatigue	12. Annoyance	18. Anxiety	24. Scepticism	30. Behaviour changes
Additional impacts self-reported in my qualitative interviews:				
1. Agitation	4. Depleted	7. Unsafe	10. Let down	13. Sleep problems
2. Violation	5. Uncomfortable	8. Suspicious	11. Feeling targeted	
3. Fed-up	6. Trapped	9. Nervous	12. Aggression	
Positive impacts reported by participants in my qualitative interviews:				
1. Calmness	2. Coping well	3. Triumphant	4. Compassion	5. Empathy
Protective behaviours identified in my systematic review:				
1. Avoidance of social activities	2. Carrying as little money as possible	3. Locking doors and windows	4. Avoidance of online banking	5.Monitoring belongings in crowded places

Protective behaviours self-reported in my qualitative interviews:				
1. Avoiding leaving the house	2. Not replacing items in case they were stolen again	3. Praying before and after leaving the house	4. Checking doors and locks	5. Carrying protective objects
6. Walking with a hand over bag	7. Checking the car had not been broken into	8. Watching CCTV		

Appendix 8: Mixed-Methods Study Materials

Appendix 8.1. STROBE statement checklist

STROBE Statement—checklist of items that should be included in reports of observational studies

	Item No.	Recommendation	Page No.
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract	159
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found	4
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	160-168
Objectives	3	State specific objectives, including any prespecified hypotheses	168
Methods			
Study design	4	Present key elements of study design early in the paper	167
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	169, 171-172
Participants	6	(*a*) *Cohort study*—Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up *Case-control study*—Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls *Cross-sectional study*—Give the eligibility criteria, and the sources and methods of selection of participants	169, 25-28, 33,44
		(*b*) *Cohort study*—For matched studies, give matching criteria and number of exposed and unexposed *Case-control study*—For matched studies, give matching criteria and the number of controls per case	N/A
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	174-175
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	36-38, 178-182,183-185
Bias	9	Describe any efforts to address potential sources of bias	173, 176
Study size	10	Explain how the study size was arrived at	172-173

Continued on next page

Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	174-177
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding	174-177
		(*b*) Describe any methods used to examine subgroups and interactions	174-176
		(*c*) Explain how missing data were addressed	177
		(*d*) *Cohort study*—If applicable, explain how loss to follow-up was addressed *Case-control study*—If applicable, explain how matching of cases and controls was addressed *Cross-sectional study*—If applicable, describe analytical methods taking account of sampling strategy	174-177
		(*e*) Describe any sensitivity analyses	N/A
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	Chapter 2
		(b) Give reasons for non-participation at each stage	N/A
		(c) Consider use of a flow diagram	
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	186, 195
		(b) Indicate number of participants with missing data for each variable of interest	N/A
		(c) *Cohort study*—Summarise follow-up time (eg, average and total amount)	N/A
Outcome data	15*	*Cohort study*—Report numbers of outcome events or summary measures over time	N/A
		Case-control study—Report numbers in each exposure category, or summary measures of exposure	N/A
		Cross-sectional study—Report numbers of outcome events or summary measures	186, 195
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	205-208
		(*b*) Report category boundaries when continuous variables were categorized	205-208
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	N/A

Continued on next page

Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	203-204
Key results	18	Summarise key results with reference to study objectives	210
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	217-219
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	212-218
Generalisability	21	Discuss the generalisability (external validity) of the study results	217-219
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	N/A

*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.

Appendix 8.2. Version of the PRSBM Approved Through Internal Review and REC for Pre-Testing (each presented on separate A4 pages)

Since the crime happened

Q1. There are things that I check regularly to try and prevent something bad happening to me

For example:

- *The locks on my doors and windows*
- *That my mobile is fully charged*
- *That any valuables I took out are still with me*
- *That my car or bicycle is locked*
- *That the lights are on when I leave the house*

NEVER | SOMETIMES | ALL THE TIME

The thing that I check the most is:

_____

_____

_____

I do this on average_____ times in a week

For me, this is:

A LOT LESS THAN BEFORE | ABOUT THE SAME AS BEFORE | A LOT MORE THAN BEFORE

Q2. I look for information or ask other people for their opinions to help me judge whether I am safe

For example:

- *By phoning friends, family or neighbours*
- *Contacting professionals (e.g. Safer Neighbourhood Teams, Victim Support)*
- *Searching the internet for local news reports*
- *Searching the internet for crime prevention information*

NEVER | SOMETIMES | ALL THE TIME

The thing that I do the most is:

_____

_____

_____

I do this on average_____ times in a week

For me, this is:

A LOT LESS THAN BEFORE | ABOUT THE SAME AS BEFORE | A LOT MORE THAN BEFORE

Q3. I go over in my head how I can prevent a similar situation from happening again

For example:

- *Planning what I would say to the offender*
- *Thinking about what I should have done differently at the time*
- *Planning what I would do if I heard someone break in*

NEVER | SOMETIMES | ALL THE TIME

The thing that I go over in my head the most is:

I do this on average_____ times in a week

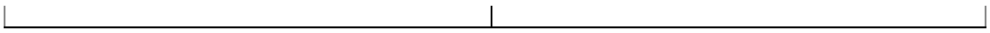
For me, this is:

A LOT LESS THAN BEFORE | ABOUT THE SAME AS BEFORE | A LOT MORE THAN BEFORE

Q4. There are certain situations, places, people or thoughts that I avoid:

For example:

- *Trying not to think about someone breaking in*
- *Going out alone*
- *Walking past certain groups of people*
- *Answering the telephone*
- *Walking down quiet streets*
- *Opening the door to people I do not know*
- *Using public transport*
- *Using online banking*
- *Going out unless someone knows where I am*
- *Going out after dark*

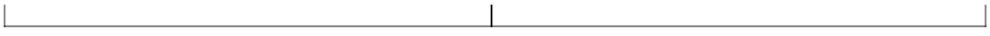


NEVER | SOMETIMES | ALL THE TIME

The thing that I avoid the most is:

I do this on average_____ times in a week

For me, this is:



A LOT LESS THAN BEFORE | ABOUT THE SAME AS BEFORE | A LOT MORE THAN BEFORE

Q5. If I suddenly think about something bad happening to me, there are little things that I think, say or do to help me feel better again

For example:

- *Saying a prayer*
- *Crossing my fingers for good luck*
- *Trying to distract myself by thinking of other things*
- *Knocking on wood*
- *Repeating phrases such as 'lightning does not strike in the same place twice' a certain number of times*

NEVER | SOMETIMES | ALL THE TIME

The thing that I do the most is:

_____

_____

_____

I do this on average_____ times in a week

For me, this is:

A LOT LESS THAN BEFORE | ABOUT THE SAME AS BEFORE | A LOT MORE THAN BEFORE

Q6. I am alert for people or situations that could be a threat to me

For example:

- *When reading my mail or emails*
- *Intentionally staying awake at night*
- *Looking out for suspicious people when walking down the street*
- *Checking the identity of people over the telephone by asking them questions only they could know the answers to*

NEVER | SOMETIMES | ALL THE TIME

The thing that I am alert for the most is:

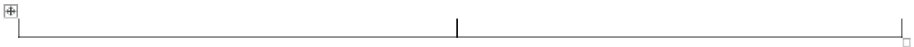
_____

_____

_____

I do this on average_____ times in a week

For me, this is:

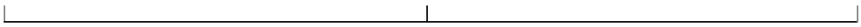


A LOT LESS THAN BEFORE | ABOUT THE SAME AS BEFORE | A LOT MORE THAN BEFORE

Q7. There are things that I do in a different way to try and prevent another crime from happening

For example:

- *Not dressing in a way that might make me look 'old' or 'vulnerable'*
- *Not wearing jewellery or watches outside the house*
- *Hiding valuables in different places around the house before I go out*
- *Walking in a way that attracts less attention*
- *Leaving a radio on when I leave the house*
- *Taking a mobile phone out with me so I can contact someone at all times*
- *Carrying something with me for good luck*
- *Sleeping with a weapon by my bed*



NEVER | SOMETIMES | ALL THE TIME

The thing that I do differently the most is:

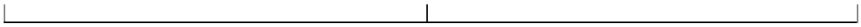
_____

_____

_____

I do this on average_____ times in a week

For me, this is:



A LOT LESS THAN BEFORE | ABOUT THE SAME AS BEFORE | A LOT MORE THAN BEFORE

If you have any other examples:

The thing that I do is:

_____

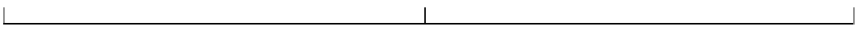
_____

_____

_____

I do this on average_____ times in a week

For me, this is:



A LOT LESS THAN BEFORE | ABOUT THE SAME AS BEFORE | A LOT MORE THAN BEFORE

Appendix 8.3 Pre-Testing Feedback Form

Pre-test notes

Visual - How does the measure look? How easy is the text to read?

Comprehensibility - Do the questions make sense?

Burden - How long does the measure take to complete?

Observation – hesitancy, confusion?

Face validity – 'What do you think the questionnaire is trying to measure?'

Internal mapping – is there an option that fits in with how the participant would answer the question

Any other notes?

Appendix 8.4 Example Version of the PRSBM During Pre-Testing Using an Anchored Visual Analogue Scale

Q1. There are things that people may check regularly to try and prevent something bad happening to them

For example,

- *The locks on their doors and windows*
- *That their mobile is fully charged*
- *That any valuables they took out are still with them*
- *That their car or bicycle is locked*
- *That the lights are on when they leave the house*

1A) Is this something that you do? ☐ YES ☐ NO *(if no, move on to the next page)*

If yes, please answer the following:

1B) The thing that I check the most is: _ _____

_____

_____

1C) I do this on average_____ times in a week

1D) I do this:

VERY RARELY — SOMETIMES — ALL THE TIME

1E) For me, this is:

A LOT LESS THAN BEFORE — ABOUT THE SAME AS BEFORE — A LOT MORE THAN BEFORE

Appendix 8.5: Final Version of the PRSBM Used in the Larger Sample (each on separate A4 pages)

Q1. There are things that people may check regularly to try and prevent something bad happening to them
For example,

- *The locks on their doors and windows*
- *Any valuables they took out are still with them*
- *The lights are on when they leave the house*
- *Their mobile is fully charged*
- *Their car or bicycle is locked*
- ***Any other examples?***

1A) Is this something that you do? ☐ YES ☐ NO (*if no, move on to the next page*)

If yes, please answer the following:

1B) The thing that I check the most is: _____
_____
_____

1C) I do this:

-3	-2	-1	0	1	2	3
never	very rarely	rarely	half of the time	often	very often	all the time

1D) For me, this is:

-3	-2	-1	0	1	2	3
a lot less than before	less than before	a little less than before	no more or no less than before	a little more than before	more than before	a lot more than before

1E) I do this on average_____times in a week. Each time, I spend on average _____doing this.

Q2. People may look for information or ask other people for their opinions to help them judge whether they are safe
For example:

- *By phoning friends, family or neighbours*
- *Contacting professionals (e.g. Safer Neighbourhood Teams, Victim Support)*
- *Searching the internet for local news reports*
- *Searching the internet for crime prevention information*
- ***Any other examples?***

2A) Is this something that you do? ☐ YES ☐ NO (*if no, move on to the next page*)

If yes, please answer the following:

2B) The thing that I do the most is: _____
_____
_____

2C) I do this:

-3	-2	-1	0	1	2	3
never	very rarely	rarely	half of the time	often	very often	all the time

2D) For me, this is:

-3	-2	-1	0	1	2	3
a lot less than before	less than before	a little less than before	no more or no less than before	a little more than before	more than before	a lot more than before

2E) I do this on average_____times in a week. Each time, I spend on average _____ doing this.

Q3. People may go over in their mind how they can prevent a similar situation from happening again
For example:

- *Planning how they would respond to the offender*
- *Planning what they would do if they heard someone break in*
- ***Any other examples?***
- *Thinking what they should have done differently at the time*

3A) Is this something that you do? ☐ YES ☐ NO (*if no, move on to the next page*)

If yes, please answer the following:

3B) The thing that I go over in my mind the most is: _____
_____
_____

3C) I do this:

-3	-2	-1	0	1	2	3
never	very rarely	rarely	half of the time	often	very often	all the time

3D) For me, this is:

-3	-2	-1	0	1	2	3
a lot less than before	less than before	a little less than before	no more or no less than before	a little more than before	more than before	a lot more than before

3E) I do this on average_____times in a week. Each time, I spend on average _____doing this.

Q4. There are certain situations, places, people or thoughts that people may avoid:
For example:

- *Thinking about someone breaking in*
- *Going out alone*
- *Walking past certain groups of people*
- *Answering the telephone*
- *Walking down quiet streets*
- *Opening the door to people they do not know*
- *Using public transport*
- *Using online banking*
- *Going out unless someone knows where they are*
- *Going out after dark*
- ***Any other examples?***

4A) Is this something that you do? ☐ YES ☐ NO (*if no, move on to the next page)If yes, please answer the following:*

4B) The thing that I avoid the most is: _____
_____
_____

4C) I do this:

-3	-2	-1	0	1	2	3
never	very rarely	rarely	half of the time	often	very often	all the time

4D) For me, this is:

-3	-2	-1	0	1	2	3
a lot less than before	less than before	a little less than before	no more or no less than before	a little more than before	more than before	a lot more than before

4E) I do this on average_____times in a week. Each time, I spend on average _____doing this.

Q5. If people suddenly think about something bad happening to them, there may be little things that they think, say or do to help them feel better again

For example:

- *Saying a prayer*
- *Crossing their fingers for good luck*
- *Trying to distract themselves by thinking of other things*
- *Knocking on wood*
- *Repeating phrases such as 'lightning does not strike in the same place twice' a certain number of times*
- ***Any other examples?***

5A) Is this something that you do? ☐ YES ☐ NO (*if no, move on to the next page*)

If yes please answer the following:

5B) The thing that I do the most is: _____

_____

_____

5C) I do this:

-3	-2	-1	0	1	2	3
never	very rarely	rarely	half of the time	often	very often	all the time

5D) For me, this is:

-3	-2	-1	0	1	2	3
a lot less than before	less than before	a little less than before	no more or no less than before	a little more than before	more than before	a lot more than before

5E) I do this on average_____times in a week. Each time, I spend on average _____ doing this.

Q6. Some people may be alert for people or situations that could be a threat to them

For example:

- *When reading their mail or emails*
- *Intentionally staying awake at night*
- *Checking the identity of people over the telephone by asking them questions only they could know the answers to*
- *Looking out for suspicious people when walking down the street*
- ***Any other examples?***

6A) Is this something that you do? ☐ YES ☐ NO (*if no, move on to the next page*)

If yes, please answer the following:

6B) The thing that I am alert for the most is:

_____

_____

_____

6C) I do this:

-3	-2	-1	0	1	2	3
never	very rarely	rarely	half of the time	often	very often	all the time

6D) For me, this is:

-3	-2	-1	0	1	2	3
a lot less than before	less than before	a little less than before	no more or no less than before	a little more than before	more than before	a lot more than before

6E) I do this on average_____times in a week. Each time, I spend on average _____ doing this.

Q7. There are things that people may start to do in a different way to try and prevent another bad thing from happening

For example

- *Not dressing in a way that makes them look 'old' or 'vulnerable'*
- *Not wearing jewellery or watches outside the house*
- *Hiding valuables around the house before going out*
- *Leaving a radio on when they leave the house*
- *Walking in a way that attracts less attention*
- *Carrying something with them for good luck*
- *Sleeping with a weapon by their bed*
- *Taking a mobile phone out with them so they can contact someone at all times*
- ***Any other examples?***

7A) Is this something that you do? ☐ YES ☐ NO (*if no, move on to the next page)*

If yes, please answer the following:

7B) The thing that I do the most is:

_____

_____

7C) I do this:

-3	-2	-1	0	1	2	3
never	very rarely	rarely	half of the time	often	very often	all the time

7D) For me, this is:

-3	-2	-1	0	1	2	3
a lot less than before	less than before	a little less than before	no more or no less than before	a little more than before	more than before	a lot more than before

7E) I do this on average_____times in a week. Each time, I spend on average _____ doing this.

If you have any other examples:

The thing that I do the most is:

_____

_____

_____

I do this:

-3	-2	-1	0	1	2	3
never	very rarely	rarely	half of the time	often	very often	all the time

For me, this is:

-3	-2	-1	0	1	2	3
a lot less than before	less than before	a little less than before	no more or no less than before	a little more than before	more than before	a lot more than before

I do this on average_____times in a week. Each time, I spend on average _____doing this.

Appendix 8.6. Codebook for SPSS

Codebook

Variable name	Data entry	Variable type	Variable description	Levels	Notes
ID	text	N/A	Participant ID number		For reference
Crime_full	text	N/A	the full name of the crime type experienced		For reference
Crime_Cat	Numeric	Categorical	crime type categorise into smaller groups	Assault = 2 Burglary = 3 Criminal damage = 5 Fraud / distraction burglary ('deception') = 6 8Robbery / aggravated burglary ('violent theft') = 8 Theft = 9	To adjust for confounding, it was necessary to reduce to a small number of categories as arson, racially agg assault and stalking were small numbers resulting in perfect correlation. Original: Arson = 1 Assault = 2 Burglary = 3 Racially/ agg assault = 4 Criminal damage = 5 Fraud / distraction burglary ('deception') = 6 Harassment / stalking = 7 Robbery / aggravated burglary ('violent theft') = 8 Theft = 9 Arson into criminal damage Racially/agg into assault Stalking into assault ('interpersonal')
Step_1	Numeric	Dichotomous	Screening outcome at step 1 on the GAD-2 and PHQ-2	Positive = 1	All participants in dataset were positive at step 1
Step_2	Numeric	Dichotomous	Screening outcome at step 2 on the GAD-2 and PHQ-2	Positive = 1 (presence) Negative = 0 (absence)	Most were positive at step 2 Positive = 75 (75%) Negative = 25 (25%) A statistician was consulted who advised the imbalance should not make a difference
Age	Numeric	Continuous	Age of participant at time of crime	N/A	For descriptive statistics on sample characteristics
Gender	Numeric	Dichotomous	Participant gender as reported through CRIS	Female = 1 Male =0	Adjust confounding
Ethnicity	Numeric	Categorical	Participant ethnicity as reported through CRIS	Asian Bangladeshi = 1 Asian Indian = 2 Asian Other = 3 Black African = 4 Black Caribbean = 5 Mixed (other mixed) = 6 Other ethnic group = 7 White British = 8 White Irish = 9 White other = 10 Missing = 999	For descriptive statistics on sample characteristics
Endorse	Numeric	Dichotomous	Whether the participant endorse engaging in the behaviour or not	Yes = 1 No = 2	
Often	Numeric	Ordinal	How often the participant reported engaged in the behaviour as recorded on a 7 point Likert scale *"I do this…"*	Never = -3 Very rarely = -2 Rarely = -1 Half of the time = 0 Often = 1 Very often = 2 All the time = 3	Ordinal variables can be treated as continuous variables (Robitzsch, 2020) If participants responded with 'no' to endorse questions, they were asked to skip to the next main question, which meant that the 'often' and 'change' sub-questions were not completed. To avoid skewing the dataset, these people were coded -3 (never) on the often sub-scale.
Change	Numeric	Ordinal	How much of a change this is since the crime happened *"For me, this is …"*	A lot less than before = -3 Less than before = -2 A little less than before = -1 No more or no less than before = 0 A little more than before = 1 A lot more than before = 3 Missing = 999	Ordinal variables can be treated as continuous variables (Robitzsch, 2020) If participants responded with 'no' to endorse questions, they were asked to skip to the next main question, which meant that the 'often' and 'change' sub-questions were not completed. To avoid skewing the dataset, these people were coded 0 (no more or no less than before) on the change sub-scale.

Appendix 8.7. PPI Feedback

[name redacted] <Email redacted> <28.05.2017>

Jessica,

1. Layout and content of questionnaire

When you presented this at the meeting you mentioned the first six factors in the table I have in front of me.

The seventh on the table and in the questionnaire, reads as an open question to capture any changes that didn't come up in answering the previous 6 questions.

On the questionnaire there is a final what I call 'open open' question. Suspect 7 and this question could be combined in one catch-all. A reason for doing this would be that the respondent might well be at a loss to understand why the last question had also been asked.

Taking the layout of each question, you instance a range of prompting 'examples', each finishing with a semi-colon. The whole string of examples can produce fatigue in the reader either because an example is over long, or because of the overall layout.

An example of overlong instance under Q3 starts 'repeating phrases', finishes 'number of times' - this is 15 words long.

And, overall, we [names redacted], suggest examples are laid out as a, possibly bulleted, vertical list. That flags up where each example begins and ends, and is easier to read, by running down the eye to capture examples of interest.

I'm not clear how this questionnaire will get to respondents and whether it will be filled out as part of a conversation or left with the respondent to fill up on their own.

The more open the question, the more the respondent might need to reflect before answering. Example Q2: 'The thing that I do the most is'

2. [name redacted], responses and matters arising

It's not clear how valuables are being dealt with, at Q1. A prompt is 'that my valuables are still with me when I am out'. Some things seen as valuable (in financial or sentimental terms) are not, in practice, portable. [name redacted], happens to have a collection of model transport vehicles, nicely displayed on a bookcase.

[name redacted], specifically mentioned that, if she goes out without her handbag, e.g. to buy a morning paper, she hides her handbag behind a cushion on her sofa. (She got security advice from our local Safer Neighbourhoods Team.)

This leads on to 'I do this _____ times a week.' Two things here. Times done will vary with circumstances, so perhaps times a week on average. Secondly, the answer will be fairly short, e.g. '4' or '3 to 4'. The space for the answer should match the length of the answer expected.

Q2. In [name redacted], case, police were extra helpful and she only dealt with them. She told friends and neighbours what had happened but looked for advice to the police. (Which leads me to the thought that it may well be helpful to let one or more of the study's police contacts suggest examples from their experience.)

Q3. Important here to get a variety of views, so that that at least one of the examples is likely to ring a bell.

It was here that [name redacted], first made the point that coping is much harder when you live on your own. ([name redacted], was widowed 37 years ago and has not had an intimate relationship since.)

I haven't got here the study's initial, background questionnaire(s). Is household composition covered? If not, my view is that it should be.

Q4. [name redacted], always identifies callers before opening the door. She wouldn't open the door at night. (Neighbours either name themselves outside, or ring ahead)

[name redacted], has a computer which she mostly uses to get answers to crosswords. 'Using my computer', as an example needs to be motivated. If fraud is in question that needs saying.

[name redacted], actual example of threats was unusual noises. Our bungalows are infill dwellings. Over my garden wall is the access road to the back of shops on our High Street. [name redacted], bungalow is further away but still affected by traffic. There's an archway that gives access to the service road. We get vehicle movements, sometimes boisterous souls, at various times of night.

Q5. After the event [name redacted], got a 'panic button' fitted in the lobby of her house. She did 'ruminate' (my term) immediately after the burglary but that has worn off with time.

Q6. Taking 'examples'. 1st: you mean reading emails? She gets nuisance calls. Her response is to put the phone back down, not get drawn into a conversation. The last example is 19 words long.

Looks to be some commonality with Q4. Suggest keeping examples as distinct as possible between questions.

Q7. [name redacted], thought walking in a way that attracts less attention would be to walking quietly and confidently; i.e. not as if vulnerable. (Incidentally, [name redacted], is as tall as myself: 6ft...)

Last question: here [name redacted], said 2 things. Because of the incident she is better informed about the sort of thing that happens, and the help available - seen as positive. She mentioned again the saliency (my word) of living alone.

Satchell, Jessica <Email redacted> <30.05.2017>

Dear [name redacted],

Thank you ever so much for taking the time to go over this for me and for providing such detailed feedback. Please pass on my thanks to [name redacted] too. I really do appreciate your input.

You've both raised some really helpful points and I've made a number of changes based on your suggestions. The points you raise about the risk of reader fatigue and confusion

in the examples is especially useful. I've bullet pointed them in a vertical list like you both suggested.

You asked as well whether data on household composition will be collected. This question is included in a separate questionnaire so I've not included it in my measure to avoid duplication, but I do agree this is likely to be an important factor.

Thank you again and it was lovely meeting you last week.

Best wishes,

Jess

Satchell, Jessica <Email redacted> <23.02.2018>

Dear [name redacted],

A while ago now you very kindly gave me some feedback on a questionnaire I've been working on. I've been road-testing the questionnaire and making some amendments based on the results and was hoping I might be able to get your opinion on a revised phrasing of the questions.

Of the two versions below, which phrasing do you think is the clearest and would sound most acceptable to the person reading it?

Version 1:

There are things that people may check regularly to try and prevent something bad happening to them.

Is this something that you do? (Yes/No)

Version 2:

There are things that I check regularly to try and prevent something bad from happening to me.

This is something that I do (Yes / No)

Looking forward to hearing your thoughts.

Best wishes,

Jess

[name redacted] <Email redacted> <06.03.2018>

Jessica,

I go for Q1. Some respondents might find the 'I' in both parts of Q2 intrusive.

[name redacted]

Satchell, Jessica <Email redacted> <06.03.2018>

Dear [name redacted]

Thank you, that's extremely helpful.

Best wishes,

Jess

[name redacted] <Email redacted> <11.05.2018>

Jess,

Q1: That any valuables they took out are still with them

The 'That' sounds formal/ official. Suggest dropping them. Think respondents can fill in any grammatical blanks...

Q1: D & E: how do respondents show which option, of -3 to +3 they are choosing.

(As an aside, recall there's a general advice when using a 'Likert scale' to give an even number of choices: point is that the uncertain tend to pick the mid-point, if number of choices is odd. This applies with less force when scaling a comparison, when 'no change' likely to be in the middle.)

Q3: suspect you've already had a debate between 'in their head' and 'in their mind' (or minds?). On balance, I vote for mind.

Like the examples given, particularly at Q7
