Sociology 4099: Victimology

Lecture Notes Week 10:

Human Agency Revisited: The Paradoxical Experiences of Victims of Crime

Victims of violent crime often complain of feeling powerless. In some respects this represents a psychological aftereffect of the crime - an experience in which something was done to them against their will that they were powerless either to prevent or to stop. However, focusing attention on the psychological aftereffects of such experiences often overshadows other important considerations. For example, there is a striking parallel between the relatively *powerless* position of "victims of crime" in legal institutions, and the largely *passive* medical ideas applied to them by various help agents. All of this may not only *obscure* the impact of institutional factors, but, taken together, act to *minimize* the role of agency among victims of crime.

This paper seeks to address these issues head on by *reframing* victimization in terms of the *interplay* between victims' social and institutional *interactions*, on the one hand, and their *agency* to cope on the other. I will proceed as follows:

(1) I will briefly outline victims' position in legal institutions;
(2) I will examine the major ideas victims' face in the medical literature;
(3) I will discuss the ramifications of legal institutions and medical ideologies in relation to theoretical treatments of human agency;
(4) Methodology
(5) Presentation of data from a qualitative study of individuals who have suffered the murder of a loved one.
(6) Discussion:
(7) Conclusion:

(1) Victims' Position in Legal Institutions:

- Our system of criminal justice is traditionally framed in terms of an adversarial process between the *state* and the *accused* where "victims" are generally not permitted to participate on their own behalf. This developed historically out of the concept of the "King's Peace";

- The "victim" has "no standing" - no legally recognized interest in the prosecution or non-prosecution of the alleged offender - to force the prosecution by the Crown of the crime against him or her, to dispute decisions to dismiss or reduce charges, or to accept plea-bargains;

- With few exceptions, "victims" do not have the right to be represented or to be heard at trial, except when called as Crown witnesses on behalf of the state;

- The development of the role of the "victim" in the British/American system of criminal law

stands in marked contrast to the situation in some civil law countries (e.g. France);

- The historical development and institutionalization of criminal procedure in Anglo-Saxon countries has very real consequences in the *interactional construction* of "victims'" experiences *during every stage of present criminal proceedings*. Constructing the parameters in this way means that victims who choose, or who are compelled to participate in the criminal justice system, have *lost control* not only of the process, but, to some extent, the degree of *empowerment* with which they approach their bereavement.

- Victims' effective agency is further limited by procedural, pecuniary, and bureaucratic impediments in dealings with civil legal institutions, such as the civil courts and the Criminal Injuries Compensation Board.

(2) Victims' Position in the Medical Literature:

Work regarding the emotional state of victims reflects three main themes:

(i) *a focus on temporal "stage models" of the grieving process*;

(ii) *an emphasis on the therapist's role in helping individuals accomplish various tasks leading to recovery;* and

(iii) *attempts at differentiating the "symptoms" of "post traumatic stress disorder" from other "mental disorders."*

Generally these models assume that, due to the debilitating nature of victimization, relatively powerless individuals must be given treatment and/or understanding. They either need psychiatric attention, or, in less severe cases, must pass through all of the stages of grief, as only time will ease their pain. Moreover, while there are some therapists who emphasize "helping people to help themselves" in accomplishing various tasks, this still implies the need for overarching therapeutic direction and control.

Critiques:

(i) The passive concepts of grieving, if accepted by either the bereaved themselves or those who would help, *obscure potential choices*, and thereby encourage and perpetuate individuals' experiences and perceptions of passivity. This serves to exacerbate rather than to alleviate the problem of helplessness (Attig, 1991:392).

(ii) These concepts do not fit well with empirical studies of active coping by victims of violent crime (Hagemann,1992:64-5);

(iii) These concepts are susceptible to the critiques of the *medicalization of deviance* elucidated by Conrad and Schneider (1980:248-52); (e.g. removal of responsibility, individualization of social problems, etc.);

(iv) Several ignore the not inconsiderable literature on *emotion-management* that has developed in the sociology of emotion (Hochschild 1983, 1990; Thoits 1990; Clark 1990);

(v) These models downplay or ignore the *interactional effectiveness*, indeed the *power* of victims to *rhetorically* control the definition of the situation and motivate specific behaviors and emotional orientations from others (Holstein and Miller, 1990; Loseke, 1993).

In sum, the dominant medical models of victimization and bereavement largely emphasize the passivity of "victims" and obscure their potential to actively deal with what has happened. This is despite a critical theoretical and empirical literature suggesting otherwise. Framing the problem of how to respond to victims in this fashion may both limit their *seeing* active coping as a possibility, and *obscure* what active means they use behind a smokescreen of symptomology.

(3) Legal Institutions, Medical Ideology, and Agency:

This unique intersection of victims at the nexus of two powerful, often intersecting institutional matrices, generates a question: *are they really powerless?* More specifically, is their presumed powerlessness a result of what has happened to them, or how they are *perceived* and *acted upon* by two of the most powerful institutions in society?

Ultimately, by examining these questions, *if evidence of human agency can be found among this group, it can likely be found anywhere.* This could expand our understanding of the grief process in general, and of “victims of crime” in particular. It might also lead to a major re-thinking of not only the role of agency, but also of the roles played by medical and legal institutions in our society.

To study this issue, one must begin by tentatively *reframing* grief as a *potentially* active process within a particular institutional and ideological context, and the “victim” as a potentially active agent. Of course, this raises the question of how to conceptualize agency. There have been a number of recent discussions of this topic.

Prus (1996) argues that "people's *awareness* of things, the ways in which they view (delineate, categorize, appreciate) these objects, and the manners in which people act toward the objects they've distinguished from other things are all *problematic in scope, emphasis, and particulars*" (1996:12).By making *self-indications* (i.e. attending to, considering, and altering their behavior) in the process of developing particular lines of action" (1996:13), reflectivity assumes its significance as "human agency" when people go about their activities and dialectically *implement* these through definition, interpretation, intentionality, assessment, and minded activities over time (1996:17).

Emirbayer and Mische (1998) argue that agency encompasses three interrelated elements: the *selective reactivation* by actors of *past* patterns of thought and action, the imaginative generation by actors of *possible* future trajectories of action in which received structures of thought and action may be *creatively reconfigured*, and the capacity of actors to make practical and normative *judgments among alternative possible trajectories of action* (1998: 971).

Referring to these as the "*chordal triad of agency*," Emirbayer and Mische assert that all three constitutive dimensions of human agency are to be found, in varying degrees, within any concrete empirical instance of action. (1998: 971-2).

This definition does not detail matters surrounding self as explicitly as does Prus, and Prus' treatment of the subject says nothing about agency in the context of victimization and bereavement. Elsewhere I have begun to deal with these issues, arguing that the murder of a loved one involves nothing less than the destruction of part of the self. While the literature suggests an enormous loss as the result of victimization or criminal bereavement in our culture, symbolic interactionist theory, particularly that based on Mead (1934), suggests that ripping away the organized social attitudes built up as the result of taking the role of a *particular* other (the deceased) does not extinguish the rest. The individual retains those social attitudes built up as a result of taking the roles of other loved ones besides the deceased, as well as the social and cultural attitudes of the groups to which they belong (i.e. gender roles). It is here where the seeds of both survivors' reactions, and of their projective coping abilities are likely to be found.

Yet, since the self is continually *evolving* in interaction (Mead, 1934), the *interactional construction*, indeed *reconstruction* of their injured selves in interaction becomes relevant. Indeed, the literature suggests that the type of support and treatment suggestions offered (or not offered) may contribute to upset and powerlessness rather than alleviate it (Miall, 1994). There are good theoretical reasons for believing that there is a *dynamic* relationship between the *type and degree of support* received by survivors, their practical-evaluative *responses*, and the *passive* and *active forms* in which their selves are interactionally reconstituted (Emerson and Messinger, 1977). This is so not only in private settings such as with family, friends, and the community (Young, 1991; Klass, 1988), but in interactions with help agents' paradigms of grief, as well as during repeated contact with legal institutions (Loseke, 1993; Sebba, 1992; Holstein and Miller, 1990; Schneider, 1985; Karmen, 1984; Supply and Services, 1983; Symonds, 1980).

Hence, a thorough examination of individuals' prior socialized orientations toward coping, plus their subsequent interactions is necessary to gain a comprehensive picture of passive and active changes in victims' selves - and hence of their agency.

(4) Methodology:

This study involved the collection, transcription, and analysis of:

(i) 32 interviews;
(ii) 22 surveys; and
(iii) 108 Criminal Injuries Compensation files.

Each of these contained detailed information on the experiences of those who had suffered the murder of a loved one, the majority of whom were parents of the deceased.

A major focus was on how survivors felt that the murder had impacted on their lives in various contexts, and the impact of each on their ultimate coping abilities.

These data, which were relatively balanced by gender, were analyzed utilizing Q.S.R. NUD*IST over a two year period ending in 1998.

(5) Presentation of the Data:

Despite the apparently powerless position of homicide survivors in both legal institutions and much current medical literature, it became clear that many survivors were capable of at least some degree of control over both their grief and social situations. Indeed, the data suggested that the relevant question is not **if** survivors used active means to cope with their losses, but **how**, and **under what conditions** they did so (i.e. made choices). Thus, to understand respondents' coping choices, we must first examine the social contexts in which they were made.

In what follows, this social context of survivors' agency will be outlined with regard to three principal matters: (i) encounters that increased or decreased their upset; (ii) information that they encountered re: coping; and (iii) coping strategies that emerged by gender. These matters will be illustrated with representative examples from their dealings with: (a) immediate family; (b) extended family and friends; (c) acquaintances, strangers and the community; (d) self-help groups; (e) other victims/survivors; (f) medical/psychological professionals; and (g) legal institutions.

(i) Matters that Increased or Decreased Survivors' Upset:. Encounters in each of the above contexts offered survivors *various reasons to be more or less upset.* Those interactions which subjects reported as *unhelpful* often further *victimized* them, leading to *additional* reasons to be upset, ongoing damage to the self, and impediments to reconstitution of the self as a functioning agent. For example, some survivors experienced conflicting emotional reactions within their immediate families:

> People assume that because you've come through something very traumatic and tragic, that you're all going to come together. But, because everyone grieves in his or her own way, and goes about it differently, it loses its cohesiveness in a very short time. That takes its toll. (Interview #18: Female, age 55).

Similarly, survivors reported being upset by the avoidance of extended family and friends:

> The only thing I remember is that I was alone - all the time. All the time. There was nobody came around. My family hasn't been supportive. I haven't seen any of my family. None of them have come, and that *hurt.* It's been two years, and I think you are the third person that's been in this house. (Interview #10: Female, age 60).

> It was an eye opener. Like, walking through a grocery store, walking down the aisle, I'd see somebody that I knew, and, before, they would talk to me. When they saw me coming, they turned their cart around and went the other way. (Interview #32: Male, age 47).

In many respects, such individuals lost more of a sense of themselves, often taking on stigmatized, isolated identities. Interpersonal difficulties with self-help and “victims’” groups had a similar effect:

> Unfortunately, a lot of victims' worst victimizers are other victims. That's what causes so many victims to fall out of the victim movement. They come in, and they're victimized by other victims, and strike out. (Interview #12, Male, age 61).

Finally, survivors’ upset was evident surrounding unpleasant encounters with medical and legal institutions in which their voice was neglected:

> You have to feel to heal. There's no two ways about it. To do that, you need to move towards your grief, not move away from it. If you try to hide from it, if you try to bury it, or you try to push it away, the longer your reconciliation will take. If you move towards your grief, then you will heal faster. And, of course, if the medical profession medicalizes it, and turns it into an illness that you can prescribe drugs for, that is really moving away from your grief. (Interview #2: Female, age 51).

> The defense was absolutely obnoxious! They did everything they could to try to break us and have us concede to a plea bargain. They did things that were very hurtful in the courtroom. (Sighs) _____ (the offender's defense counsel) deliberately stood six to eight feet in front of us with pictures of _____ (the deceased) that they took after they found her body - and they were facing us, not the witness, not the jury, not the judge. They were facing us, and we had never seen these pictures. We didn't want to see these pictures. (Sighs) so it was like emotional blackmail. ((Interview #32: Female, age 46).

> I had a real hard time because, on the one hand, I had RCMP, Crown, etc. telling me to keep trying to remember details, and, on the other hand, I had Criminal Injuries, doctors, friends, family, and counselors trying to help me forget and get on with some semblance of a normal life. How can you do this and stay sane? (Survey #6: Female, age 37).

Such survivors often came to see themselves as more victimized, more helpless than ever.

On the other hand, survivors experiencing what they interpreted as helpful interactions in these contexts had fewer *additional* reasons to feel victimized, and hence fewer ongoing impediments to functioning in their day to day lives. For example, survivors with much familial and community support did not have the additional reasons to feel victimized as those who did not. Some spoke of a relatively active *synchronization* of reactions in their immediate family such that the individuals who most needed support at a given time were able to receive it. In the words of one woman: "We kind of leaned on each other, cause when one was up the other one was down and vice versa" (Interview #1: Female, age 47). This could be complemented when extended family and friends offered ongoing, continuous support:

> I’ve always had people really look after me. I’ve never been left to do this alone - and that made a huge difference. My friends were there morning, noon and night for at least two

> years, which made me feel good - to know that they were there for me. (Survey #19: Female, age 45).
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> There was an overwhelming response from our family and friends, which is wonderful, absolutely wonderful. I mean, the friends that we had stayed with us, and supported us, and continued to support us afterwards. Every one of them is still there today, as strong as they were then. The support, you know, the support that you were looking for was always before anything. It was natural. It was there from their heart. (Interview #4: Male, age 56).

Indeed, at times survivors received widespread support from acquaintances and the community as well. Some survivors, for example, noted that individuals who had previously been mere acquaintances became very supportive, while others noted that their local communities rallied around them, provided letters, cards, meals, volunteers, and campaigned for justice on their behalf.

Such supportive encounters could be further buttressed by supportive encounters that survivors experienced in self-help and victims' groups:

> As I reflect back, the other mother (in the group) and myself were non-functioning as whole, living human beings, but rather as robots just trying to get through each long, dark day. In our group, for the first time we could cry freely, holding no tears back. Not having to be strong all the time is very therapeutic. We could question, get angry, and we could wonder aloud if we could ever be able to find meaning in life again. It wasn't until I found solace in the group that the healing process began. I found a place to unload my anger, fears, and frustrations. Healing starts with the opportunity to share intense emotions with others who've experienced the same. I can come here, and we can dump on each other without criticism. (C.I.C.B. #87: Female Survivor Quoted in Newspaper Article, age 65).

Similarly, survivors could find supportive encounters in their dealings with medical professionals:

> We went to marriage counseling, and, I tell you, it saved my marriage. The counselor said 'Part of the problem is people have to learn to communicate.' Cause we weren't talking. We weren't doing nothing. He says 'You've got to learn to communicate.' The, the other part was doing little things for each other. Those little things sure made a big difference (Interview #21: Female, age 45).
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> They took us through the grieving, they took us through the denial. There was a birthday coming up, they built us up to that, they built us into Thanksgiving, they built us into Christmas, and they did it so professionally that we could slowly get ourselves up to do these things (Interview #26: Male, age 61).

Finally, survivors reportedly faring better often had minimal or no involvement with the criminal justice process, which invariably was experienced as detrimental to coping. As one

respondent put it:

> We both discussed that we didn't want to get involved with the court case. I see in so many cases, and with the support groups, that if you do get involved in any of the court cases, you're emotionally involved, and you can't get on with your grief. So, when I think back, I think that was a wise thing to do. (Interview #5: Male, age 50).

The upshot of all this is that survivors' encounters in various social and institutional contexts either gave them reasons to be upset *in addition* to the murder, or in some way helped *offset* or *mitigate* their sufferings on that account.

(ii) Information that Survivors Encountered re: Coping: Next, these various interaction contexts frequently involved *information* on *how to deal with their experiences*. While survivors found such information useful in varying degrees, *awareness* of such strategies undoubtedly had an impact on both their ultimate coping choices and ability to function. For example, some found helpful encouragement by *observing* immediate family members attentively taking turns and supporting each other:

> I think that one reason why our family has dealt with it this, well, what I consider successfully after I've seen some other families, is because there is an openness in our family. There is support in our family, but there is also a respect for everyone else's space...Basically, if one of us is having a bad day and the other one is reasonably OK, we kind of take turns and take the slack for each other. I guess we read each other well, so it really helps. (Interview #24: Male, age 47).

By thus actively taking the role of the other, and learning to gradually change not only their own intimate, personal experiences of grief, survivors not only discovered ways to deal with their own upset, but more typically avoided the evolution of further upsetting family dynamics as a result (e.g. blame, taking others' blame, anger and upset personally, and taking one's upset out on others). Conversely, survivors who encountered severe, conflicting reactions within their families, coupled with adherence to rigid gender roles, poor communication, and lack of synchronization generally typically found themselves *hemmed in.* They faced the choice of either focusing on how their evolving family problems further upset them personally, or of finding a way to cope on their own.

But beyond such observational methods, those encountering extended family, friends, acquaintances, and, particularly, other survivors with whom they could identify, often noted helpful suggestions that made them *aware of choices* as to how to deal with particular problems:

> My mother in law phoned in the middle of the night every night, and she's the one person who really gave me the advice I needed. She just basically said 'Look, my God, don't stop.' But nobody told me don't stop before. She said 'Put your head down in your work, that will get you through.' It's absolutely true. (Interview #17: Female, age 50).

> I have a friend who lost his son. Well, because of his loss, he had sought help with a self-help group. So, knowing what had happened to me, to us, he went on to tell me about the

> group, and he told me about himself, and how his grief had been helped. He highly recommended it, saying that he wouldn't have survived without them. So, I approached my wife, and we went from there. It was valuable in dealing with our anger and grief. (Interview #4: Male, age 56).

Indeed,, widespread community responses such as those noted above at times encouraged respondents to forming victims' rights organizations in which they worked their grief out through activism.

> I went on the radio (to thank the community search teams). A policeman phoned in and said 'I searched for (the deceased), now what are you going to do?' And that's how I started. I wrote a petition, and this whole thing kept going and kept going. So that is how _____ (this survivor's organization) happened. People just kept coming to us and saying 'what are you going to do?' There was never a day when the phone didn't ring thirty times. (Interview #17: Female, age 50).

Third, it was often the case that survivors who encountered predominantly unsupportive responses found themselves, to a certain extent, "hemmed in." Their social isolation and/or notoriety frequently left them the meagre choice of either *focusing* on how these restrictions further upset them personally, or of *finding* ways to cope on their own. In many cases, it was clear that they perceived this as an overwhelming burden, and many simply chose to avoid others and attempted to deal with their upset in a solitary manner (e.g. avoiding social contact, withdrawing from prior involvements, installing security systems, taking trips or moving). Others, however, *perceived more room to manoeuvre* within this restrictive framework and *innovated* more interactional strategies. For example, "floating trial balloons" to put others at ease and gauge their potential reactions, briefly mentioning their ordeal at work to give others tacit permission to speak, changing the subject when uncomfortable, denying their identities when approached or singled out in public, warning others about "inappropriate comments," or expressing anger. In these latter cases, "taking the role of the other" provided survivors a *framework* within which they could creatively innovate a variety of interactional strategies to help cope with the responses of others.

Finally, it is important to note that the information encountered in these social contexts often contained an *ideological* element, most notably in interactions with some self-help, "victims'" groups and medical professionals. Sometimes this encouraged the reconstitution of the self in a *passive* mould with a similar effect on coping ability. For example, some found themselves recast as "victims" encouraged to continually rehash their upset. Survivors in this category often reported "cross-contamination": subtle, and sometimes less than subtle - suggestions regarding "how they should feel", "how they would feel", and having half-digested medical ideas about the course of grief pushed on them as gospel - all at a time when survivors felt particularly vulnerable to suggestion:

> You go to a group and you start listening how other people feel and you think 'That's the way I'm supposed to feel.' You take on - especially when you're hurting - you look for something that makes sense. That can do more harm than good. (Interview #6: Female,

age 46).

Indeed, some groups even distributed brochures outlining the *passive* "stage models" of grief, which, often does little to encourage active coping by survivors (Attig, 1991). This suggests that many of the problems inherent in the medicalization of deviance may, in some cases, be fostered by these groups as well (Conrad and Schneider, 1980).

Similarly, in their encounters with medical professionals, in many of the cases where survivors felt they fared worse, professionals initially viewed survivors as somehow limited, weak, and incapable of coping. Such professionals tended to identify the source of the problem *within* the individual (e.g. "endogenous depression"/ "biological changes in brain functioning"). Not surprisingly, when therapy did not go well, such mental health professionals tended to focus on individual-level factors to explain their lack of success, such as clients' "insufficient response" to treatment (C.I.C.B. #13: Female, age 48). On the other hand, any improvements in survivors' condition were typically credited by professionals to drug treatment, "psychotherapeutic intervention," or both (C.I.C.B. #96: Male, age 60). Given such an *individualistic* orientation, survivors were often officially labelled by such professionals as suffering from some type of psychological disorder, such as PTSD (C.I.C.B. #55: Female, age 36). Given their orientation, such professionals typically considered survivors under their care to require a great deal of professional help in the future. Indeed, survivors were told as much:

> My psychiatrist told me that I would have to go and see him for a good length of time. I asked how long did I have to go and see him, and he said that he did not know - but he said he wanted to see me every 3 weeks instead of 6. (C.I.C.B. #2: Female, age 45).

Moreover, many of these professionals *themselves* felt that survivors would "never fully recover" from their loss (C.I.C.B. #13: Female, age 48). Such an orientation by doctors and mental health professionals affected their perceptions of survivors' problems, and such a definition of the situation shaped their further interactions and constructions of appropriate coping strategies (e.g. long term treatment).

On the other hand, there were countervailing ideological elements in these contexts, such that individuals were afforded the opportunity to learn active coping strategies. For example, in some victims' groups there was an active ideology that helped restore at least some sense of direction and control.

> If enough people get together maybe something, someday will be done. But, if we don't fight, we might not get anything. Working as part of a group to change the Canadian justice system makes you feel like you are doing something about it. At least you aren't sitting around doing nothing. (C.I.C.B. #1: Female, age 32).

Moreover, by getting involved, such survivors reported that they were able to share skills, and divide up their chosen tasks in a functional, efficient way, thus enabling them to accomplish more than they would have been able to otherwise. Significantly, these survivors also reported making important contacts - obtaining information and support from survivors and associates of

victims' organizations dealing with outside bodies. For example, some groups helped survivors learn what rights they had, helping to guide them through the pitfalls of the justice system by letting them know what to expect, providing emotional support at hearings, helping them to obtain specific information about their case, and lobbying on their behalf - for example, against parole for the offender. In addition, survivors reported that contacts made through survivors and victims' rights organizations provided specific help in their applications for compensation. For example, some were advised of the existence of Criminal Injuries Compensation by these organizations. Other survivors' contacts provided letters of support in their ongoing dealings with tribunals, as well as emotional support at hearings. Indeed, survivors' working with survivors and victims' rights organizations helped in a variety of institutional contexts, helping them deal with the media, to find appropriate counselling, and even giving advice on forming their own groups and organizations. These contacts provided a great deal of useful information that facilitated survivors in making helpful coping choices.

Similarly, there were doctors, psychiatrists, and other mental health professionals with a far broader orientation than above. For example, *despite* their patients' exhibiting quite severe upset when first observed, rather than focus so strongly on individual factors, these professionals frequently located the problem in the survivor's current situation. In the words of one doctor:

> In essence we have a case of a well-adjusted family oriented woman whose home life has been tragically upheaved by the shock of the tragic events that have befallen her (C.I.C.B. # 56: Female, age 57). [1]

Significantly, these medical professionals did not focus as heavily on long-term medical treatment. Instead, by focusing on making survivors *aware of their options*, they frequently offered brief, practical assistance and suggestions to survivors to help them to deal with problems in their environment flowing from the murder (e.g. decision making or dealing with family conflict). Such professionals, perceiving situational problems to be as significant as

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[1]The outcome of subjects' encounters with medical professionals were the result of an interplay between: (1) the *ongoing severity of survivors' upset;* and *(2) professionals' general orientations* to survivors and their problems. While the former was a factor with a wide variety of influences as outlined throughout these data, varying professional orientations were observed to be at the root of many reported aggravating and mitigating interactions influencing both survivors' assessments of the *care they received*, and their *coping abilities*.

While it may be objected that many of the survivors reportedly faring worse could have fared worse in any event, I respond that the nature of the data does not allow for any completely "objective" measurement of who ultimately fared better or worse - indeed, even medical professionals with their standardized psychological tests come up with differing diagnoses of the same survivor, and such differing professional assessments of the severity of individual survivors' reactions were clearly observed throughout the data. The only common thread running through all of the varying sources of data were the words of survivors with relation to *types* of *interactions* in particular *contexts* that *they* found helpful or harmful - *which is the focus here in any event.* Moreover, by careful triangulation and negative case testing between the sources of data, the potential biases inherent in the demand characteristics of the C.I.C.B. were offset by the accounts and observations of survivors outside this context, particularly considering that these files were generally *used only when related patterns were observed elsewhere*. Under such circumstances, when the data became saturated with repetitive codes, "practical certainty" was achieved to the extent that it could be under the circumstances.

individual ones, frequently made suggestions or wrote supportive letters regarding survivors' employers, landlords, creditors, politicians, Members of Parliament, and the Parole Board, to name just a few. They also interceded with the C.I.C.B. on behalf of survivors, over and above the standard medical reports they were required to submit. Not surprisingly, such professionals more often gave survivors a good long term prognosis *despite* their exhibiting quite severe upset when first observed. Such a broader initial orientation, more reflective of a "task oriented" models of grief, when coupled with an implicit belief in survivors' abilities, had an effect on professionals' interactions with survivors, and survivors' orientations toward active coping, in a different way from those first discussed.

So, in the end, survivors encountered a variety of information regarding how to cope, both observationally, by being given specific advice, innovating in specific interactional frameworks, and through the presence of ideological elements in various institutional contexts.

(iii) Coping Strategies that Emerged by Gender: Finally, there were the *actual strategies* that survivors, depending on their past personalities *and* subsequent encounters, *chose, learned, or innovated* in these contexts. Sometimes these varied by gender, and were rooted in unquestioned adherence to traditional gender roles. For example, many "traditional" men repressed and avoided their feelings through work/activity, while traditional women withdrew from employment, and continually expressed emotions associated with grief. Often these choices raised tensions family, as the words of one man express:

> It's tough going out to work. For a long time I never said a word. I just tried to go in and do my job. I'd leave the house with a wife that is so frustrated, so down crying, that, when you left to go out to work, you thought 'Oh shit, is it even worth going?' But I'd go. Then, I'd go upstairs when I came home. Bang! It would start again. She'd start at me again. It's been tough on me. (Interview #26: Male, age 61).

In other cases there was no gender difference. For example, many survivors *chose* to avoid traditional repression or emphasis on their grief by *balancing* times of activity and time for grieving; time for others and time for themselves

> My husband and I are very close, and I would see that, of course, he was in a huge amount of pain, so I would try to be strong for him, which meant I have to hold off, OK? Give him a turn, and then he would hold off and give me a turn. With us, it just happened that we were able to support each other at a time when we needed each other. (Interview #2: Female, age 51).

Indeed, sometimes individuals of either gender *integrated* time for "grief work" into their daily routines. For example, both men and women spoke of how they innovated by doing their crying in the car on the way to and from work, such that they could "get it out" as necessary, but also focus their thoughts elsewhere for a significant part of the day.

> Like, I'm in the car all day long. In and out of customers. But I find that's where I got a lot of my relief. When you're in the car, you're in there by yourself. But then, when you're

> going into a customer, you knew quick you had to straighten up like that (snaps fingers). I was able to pretty well control things during the day, cause I knew I had to go to the customers. That gave me a lot of relief. (Interview #30: Male, age 64).
>
> Going to work, *I could deal with it in reasonable chunks*. I find - and I still find - going back and forth to work in the car is when I would bawl my eyes out, just cry. I like opera, and I took every tragic aria that I could lay my hands on. I put it in the car, I cranked it up loud, and I cried my eyes out driving back and forth to work. But I got it out. (Interview #2: Female, age 51). (Emphasis added).

Learning about their emotions from their own (or others') experiences, such individuals were "gentle" with themselves, and did not push either their "grief work" or their other activities too hard. Instead, they learned to *balance* these in a *flexible* way that enabled them to work through their grief a bit at a time in more easily digestible "chunks."

There are numerous other examples of gendered coping strategies that survivors chose, learned, or innovated in particular social contexts. Some survivors, faced with avoidance from others, *innovated* by seeking out others in similar situations for support (women), or discovered that briefly talking about it at work put co-workers at ease (men). Many women utilized self-help and victims' groups as an "outlet" for a time, but withdrew after their involvement no longer relieved pressure but began to re-intensify their upset. Similarly many women faced with mental health professionals that did not meet their needs either "hedged" by remaining emotionally unavailable, or simply chose to quit and find another. Finally, women who experienced a difficult time with the justice system, more often than men, found innovative ways to fight back, such as lobbying politicians, using the press to their advantage, or getting their own lawyers to pressure the prosecutor.

(6) <u>Discussion:</u> Coping has been discussed in a variety of contexts in terms of matters that increased or decreased survivors' upset, information that they encountered re: coping, and coping strategies that emerged by gender.

Survivors were very clear that coping is *not* recovering completely, returning to "normality," or going back to the way that they were before the murder. Instead, survivors referred to an ability to live their lives "around it" and "go on" *despite* this permanent life change. They noted this ability to *function* in their day to day lives required a lot of *effort* - effort that one has to want to exert to "deal with it in your own mind" and not "become a victim." This suggests not only an element of *choice*, but *agency*.

Some survivors almost automatically chose to follow pre-established patterns, such as repressing or emphasizing their emotions as prescribed by traditional gender roles. Such survivors, hemmed in by their *unquestioned* adherence to pre-established behaviour patterns, also generally *assumed* that their social environments left them with no choices. In contrast, many other survivors reflexively *chose, learned or innovated* strategies to cope with their upset.

Considering that various social contexts permeate the choices made, the tactics learned, and the

strategies innovated, it was found useful to view the social construction of survivors' agency in terms of a *corridor* with many doors **(Figure 1)**. Each represents a different type of encounter, such as those with family, friends, the community, self-help and victims' groups, medical professionals, and legal institutions. Individuals could choose to "knock" at a particular door, where they sometimes would find a welcoming response, other times not, such that they chose to move on. Sometimes they were initially welcomed in, but later chose, or were forced to leave and move on. Other times, once inside, they had a harder time leaving (e.g. witnesses in the justice system).

Each encounter offers survivors several elements impacting on agency. First, they contain *various reasons to be more or less upset.* Those interactions which subjects reported as *unhelpful* often further *victimized* them, leading to *additional* reasons to be upset, ongoing damage to the self, and impediments to reconstitution of the self as a functioning agent. For example, survivors who were avoided by extended family and friends lost more of a sense of themselves, and often took on stigmatized, isolated identities. Interpersonal difficulties with self-help and “victims’” groups had a similar effect, as did upsetting encounters with legal institutions in which they had no voice. Such survivors often came to see themselves as more victimized, more helpless than ever. Conversely, survivors experiencing what they interpreted as helpful interactions in these contexts had fewer *additional* reasons to feel victimized, and hence fewer ongoing impediments to functioning in their day to day lives. For example, survivors with much familial and community support did not have the additional reasons to feel victimized as those who did not.

Next, these contexts frequently involved *information* on *how to deal with their experiences*. While survivors found such information useful in varying degrees, *awareness* of such strategies undoubtably had an impact on both their ultimate coping choices and ability to function. For example, some found helpful encouragement in attentively taking turns supporting each other in their immediate family environment, actively taking the role of the other, and learning to gradually change not only their own intimate, personal experiences of grief, but more typically avoiding the evolution of further upsetting family dynamics as a result. Moreover, those encountering extended family, friends, acquaintances, and, particularly, other survivors with whom they could identify, often noted helpful suggestions that made them *aware of choices* as to how to deal with particular problems (e.g. keeping busy / self-help groups).

Significantly, the information encountered in these social contexts often contained an *ideological* element, most notably in interaction with some self-help, “victims’” groups and medical professionals. Sometimes this encouraged the reconstitution of the self in a *passive* mould with a similar effect on coping ability. For example, some found themselves recast as “victims” encouraged to continually rehash their upset. Similarly, among survivors interacting with medical professionals, some encountered “individualistic” counsellors with ideologies and treatment modalities that often cast them into helpless roles. Yet, there were significant variations among both self-help organizations and medical professionals in this regard, others encouraging a view that certain feelings and behaviours were "normal" under the circumstances and exhibiting an *active* approach to coping.

Finally, there were the *actual strategies* that survivors, depending on their past personalities

and subsequent encounters, *chose, learned, or innovated* in these contexts. Sometimes these varied by gender, sometimes not. In many cases, for example, survivors *chose* to avoid traditional repression or emphasis on their grief by *balancing* times of activity and time for grieving; time for others and time for themselves, thereby *integrating* time for "grief work" into their daily routines (e.g. men and women who did their daily crying in the car on the way to and from work). *Learning* about their emotions from their own (or others') experience, they were "gentle" with themselves, and did not push either their "grief work" or their other activities too hard. Instead, they learned to *balance* these in a *flexible* way that enabled them to work through their grief a bit at a time in more easily digestible "chunks." Some survivors, faced with avoidance from others, *innovated* by seeking out others in similar situations for support (women), or discovered that briefly talking about it at work put co-workers at ease (men). Similarly many women faced with mental health professionals that did not meet their needs simply chose to quit, and sometimes find another. Finally, women who experienced a difficult time with the justice system found innovative ways to fight back, such as lobbying politicians, using the press to their advantage, or getting their own lawyers to pressure the prosecutor.

The variety of coping strategies encountered throughout these data confirm that the relevant question is not *whether* active coping takes place, but rather, what are the *social conditions most conducive to it*. Indeed, a great irony emerges: to some extent, that the *degree* and *form* of *agency* that survivors employed in attempting to cope with murder loss *was itself partly a product of social interaction*. It was *not* socially determined, but the coping choices individuals made, and were consciously *aware* of, were at least partially *shaped* by the people, situations, and ideas that they *encountered* in different settings. These constituted the *framework* in which survivors coping choices were made. While subjects frequently had coping choices, some faced with similar situations chose them, while others didn't. The relative *extent* of one's *engaged agency* thus appears to be *socially influenced* by a combination of the self one brings to interaction, the content of the interaction itself, and how reflective, active individuals, by taking the role of the other, *actively synthesize* these into either *innovative* or largely *pre-patterned* responses.

It would be absurd, in light of the above, to assert some form of radical free will theory suggesting that agency exists irrespective of social context. Yet, the variety and innovation shown by survivors offers a challenge to those who advocate a strict social determinism. Mead's (1934) conception of the self is useful in resolving this dilemma. The self, according to Mead, is composed of two elements: the internalized attitudes of society, termed the "me", and something that he termed the "I", that impulse that individuals contribute to the formulation of unique responses in interaction. It is this "I", this unique aspect of humans which allows for consideration of agency in action. More specifically, in any interaction, the individual must *interpret* what is said by the other and formulate a response. The interpretation and formulation depend on the self assessing the "generalized other", but it is particularly in formulating a response that the "I" in interaction with the "me" produces the novel or creative response.

Depending on the content of an individual's past socialization, and how this content is utilized in current interactions, it may be that *some individuals will draw more heavily on past, socialized patterns of response* more characteristic of the "me." For example, individuals in this study

appeared to draw on traditional gender based coping styles in response to grief, either repressing or expressing it, or they adopted a more balanced approach which incorporated both styles. Either of these lines of action could reflect the predominant influence of internalized social attitudes. Similarly, some respondents appeared to internalize and incorporate, without judgement, what they encountered in interaction, for example, medical diagnoses or conceptions of the grief experience from therapists. Others, however, reported the *active synthesis of new ideas or coping strategies* with past experiences, and/or the creation of new and, for them, original responses or ways of acting.

These data suggest such an extension of the Meadian perspective is a useful way to *balance* evidence of social influences on the grief experience, on the one hand, and data showing individual initiative and originality in coping, on the other. Indeed, they suggest that human *agency*, and the *form* it takes in coping choices, are *socially constructed* in interaction between: (1) reflexive, self-aware individuals faced with options; (2) various "tried and true" choices available in the "me" portion of their selves, dominated by the "generalized other"; and (3) interactional choices presented by specific stressor(s) and individuals in the unique context of the current interaction. These are *synthesized* by the individual into a new "I" response which is incorporated into the individual's sense of self, which may or may not be helpful. Some will be more reflective of past socialization and uncritical internalization of interactional content; others will show evidence of an original individual synthesis regarding how to cope under particular circumstances.

The data certainly appear to bear this out, with some survivors appearing to repeatedly make choices rooted in their past socialization, at times leading to the intensification of grief, while others, who internalized more flexible patterns, avoided this. Some survivors simply internalized the contents of the various helpful and harmful interactions, including the ideas on coping found among family, friends, support groups and medical professionals; others were more critical and produced creative, original ways to cope in various interactional contexts, thus enabling them to "live with it" and gradually return to functioning. Naturally, the frequency and type of survivors' interactions with family, friends, the community, legal institutions and help agents play a part here, as do the coping ideas that they bring to the interactions.[2]

Finally, before closing, it must be noted that perhaps the best evidence of this contrast was in *how survivors ultimately related to the victim role.* Some, due to past inclination or subsequent encounters, simply *refused to call themselves "victims"* altogether, rejecting the implicit connotations of weakness and helplessness. Others, while coming to call themselves "victims," emphasized distinct *aspects* of this role. Some used the victim role "*as a shield"* to deflect criticism and justify their present inability to engage in some activity or responsibility. Others came to use the victim role "*as a sword*" to achieve goals in a given situation, such as fighting for change to criminal justice institutions "because I know what it's like so you'd better listen to

[2] While survivors facing more stressors may make different choices than those who do not, and, indeed, may have fewer options, this does not mean that they have no choices. Indeed, even if survivors withdraw totally and allow their emotions to take over, these are still choices that they make on an ongoing basis.

me." Indeed, there was evidence that some victims *alternated* between these two characterizations as the situation demanded - a micropolitical, self-presentational strategy I term "*volitional gerrymandering*."

(7) <u>Conclusion:</u> This study points to a number of interesting conclusions about agency that have important implications in a variety of contexts. A careful examination of the circumstances faced by survivors, the information that they encountered, and the coping strategies they employed, suggests that the important question is not so much *if* active coping occurs, but rather *under which social conditions agency is likely to be most evident*. The data indicate that various coping choices and strategies take place in a wider social context which *influence, but do not necessarily determine the form that coping strategies take*. Much of the data was illustrative of an interplay between contextual factors that exacerbated and mitigated survivors' grief experiences, information that they encountered, and gender differences in coping.

The data in this study suggest that agency is far more widespread than previously thought. Indeed, it showed that survivors *learned, chose and innovated* a variety of ways to deal with their loss. They also developed many techniques for dealing or not dealing with stressors in their immediate family environment, problems with extended family and friends, difficulties with acquaintances, strangers and the community, subsequent activities and involvements, and their often difficult interactions with legal institutions. Moreover, not only did they choose self-help groups, victims' rights organizations, and medical professionals as means of coping, they developed coping strategies to deal or not to deal with further difficulties they encountered in these settings.[3] If such widespread evidence of agency can be found in a situation as traumatic as homicide, this suggests that it can be found in other bereavement situations. Further research is clearly needed in this area.

These findings stand in stark contrast to the accepted characterization of "victims" underlying many of the treatment modalities advocated by medical and psychological professionals. Much of the psychological literature, particularly the medical and stage models, *implicitly limits the agency* of individuals in coping, suggesting that there either stages that they must pass through before resolution, or that they are suffering from a variety of mental disorders for which they need treatment. As such, subjects are seen as *largely incapable* of actively coping on their own without intervention. Even the more task-based models stress how it is advisable for subjects to have professional *assistance* to accomplish various matters leading to recovery. *Uncritical acceptance* of such professional orientations sometimes run the risk of turning into self-fulfilling prophecies. For example, in contrast to the traditional psychological literature that stresses how an emphasis on one's grief, or on getting in touch with one's feelings of loss can be therapeutic, these data suggest that counsellors uncritically advocating these approaches, or *overemphasizing* them, can overwhelm survivors and exacerbate their experiences of grief.

Specifically, one theme running through the data on survivors faring better was their ability to *actively balance* their reflection on their grief with periods of activity in other areas. This

[3] Indeed, not coping by letting one's emotions take over is in itself a choice that is made each time one faces upset, and an example of the human agency referred to above.

enabled them to take their minds off themselves and their grief for a while, and to focus on others or some form of engaging activity. Survivors who thus integrated their reflections on grief into their ongoing lives were able to deal with their feelings in "reasonable chunks" a bit at a time, and generally avoided intensification through either *emphasis* or *repression* to the degree experienced by others rigidly adhering to traditional gender roles. These data should give clinicians pause over how often and how long they encourage survivors to "ventilate" their feelings, and further suggest a long list of practical strategies in various contexts that they may encourage survivors to adopt as well. Indeed, these data suggest a restructuring of several accepted paradigms to broaden the emphasis on human agency and gender in coping.

Of course, coping ideas are key. It appears from the data that many survivors were simply *not aware* of the choices available to them, while others forged ahead choosing a variety of strategies. Moreover, it was apparent, particularly in survivors' interactions with support groups and medical professionals, that they sometimes encountered coping *ideologies that effectively limited their choices*. Other professionals, with a more broadly based orientation, suggested alternate ways for them to work their own way through their grief. If anything, it was this latter type of support, where survivors were encouraged to *see the choices available to them*, that was most conducive to the active, “functional” coping expressed by many respondents.

All of this is firmly in line with the literature criticizing these models for their downplaying of human agency. These data appear to both empirically corroborate this approach and greatly elaborate the variety of coping strategies presented by Attig (1991) in relation to the bereaved, and Hagemann (1992) in relation to victims of violence; for example, in survivors' coping with self-help and victims' rights groups, the medical profession, and the criminal justice system. They also add a new context and variety of strategies to the literature on emotion management presented by theorists such as Hochschild (1990) and Thoits (1990). Indeed, the literature on the interactional effectiveness of the victim role (Holstein and Miller, 1990) appears to be corroborated to some extent, for example, in the contrast between those survivors who used the victim role as a "sword" to educate and fight for change, and those others who used it as a "shield" to justify their otherwise passive behaviour.

These data are also illustrative of the literature suggesting that the type of support and treatment suggestions offered (or not offered) may either be the most important factor helping survivors to cope (Klass, 1988), or may contribute to their upset and powerlessness rather than alleviate it (Miall, 1994). Indeed, these data corroborated the theoretical literature suggesting a dynamic relationship between the type and degree of support received by survivors, on the one hand, and the passive and active forms in which their selves were interactionally reconstituted, on the other (Emerson & Messinger, 1977).

Summing up, the data in this study illustrate how individuals suffering the homicide of a loved one actively coped with a wide variety of stressors. Evidence of agency under such extreme conditions suggests a widening conceptualization of the role of agency in several current psychological models of grief to balance potentially inhibiting factors therein. While the variety of coping strategies documented in previous literature on agency and emotion management is undoubtedly elaborated and extended by attention to this unique empirical situation, these data

also indicate that emergent strategies must be grounded in their social contexts. Since the role of gender and various social interactions played such a large role, it is suggested that *agency itself is a social construct*, and the *forms* that it takes emerge in the accumulative interaction between past socialization, ongoing social interactions, and reflexive, self-aware individuals capable not only of choices, but of innovation as well.