Sociology 4099: Victimology

Lecture Notes Week 8:

Victims and the Medical/Psychiatric Profession

Up to this point, we have largely been looking at victims in either unofficial settings, or with regard to legal institutions. Victims interactions in unofficial social settings were shown to not only have a definite impact on their long-term emotional adjustment, but informal labelling in such contexts significantly impacted on whether they became involved with self-help groups and counsellors. Similarly, victims frequently upsetting, powerless encounters in legal institutions not only gave them many more reasons to be upset, an offer of counselling from victims services, support groups, or criminal injuries compensation was frequently the formal response. Today we will take these as our point of departure in critically examining some of the literature on victims in their dealings with the medical/psychiatric professions.

We will begin by reviewing the dominant medical paradigms that are applied to contemporary victims of crime. Following this, we will critique these by examining:

(a) Medicine as an Institution of Social Control;
(b) The Unwarranted assumption of Cultural Universality;
(c) Critical Literature on the Grief of Parents and Survivors.
(d) Their Potential Impact on Victims' Social Comparison Processes.

We will then review an interesting piece by a noted Canadian psychiatrist who has criticized her profession from the inside. Finally, we will review some of my own data in this regard.

(1) <u>Medical-Psychological Models of Grief:</u> Recent work regarding the psychological state of crime victims reflects three main themes:

(i) A focus on temporal "stage models" of the grieving process: (Kubler-Ross 1969; Cohen and Ahearn 1980; Seyle 1982; Symonds 1983; Schneider 1984; Bard and Sangrey 1986; Knapp 1986: 124-53; Rando 1986:13-24; Ford and Ford 1987; Gilliland and James 1988; Kamerman 1988:127-8; Rosen 1990; Young 1991:33-9; Casarez-Levison 1992:51-5);

(ii) An emphasis on the therapist's role in helping the patient accomplish various tasks leading to recovery, an approach influenced by the works of John Bowlby (1969-1980), (Worden, 1982; Klass, 1988:151-87);

and, in the more severe cases:

(iii) Attempts at differentiating the "symptoms" of "post traumatic stress disorder" from other "mental disorders" (Walker 1992; Brown 1988; Douglas and Colantuono 1987; Figley 1986; 1988; Piquet and Best, 1986; Rosewater 1987).

With regard to the first approach - the widely prevalent "stage models" of human grief -

proponents have generally proceeded from a traumatic incident, such as terminal illness, death or divorce, and then attempted to discern temporal uniformities in the emotional states and behavior of grieving individuals. For example, Elisabeth Kubler-Ross (1969), one of the earliest and best known of such researchers, outlines a five-part process experienced by those individuals facing imminent death and loss: (a) denial - a buffering of feelings; (b) anger - the displacing of rage; (c) bargaining - the negotiation for time; (d) depression - the experiencing of intense emotions and loss; and (e) acceptance - a surrendering to the imminent loss. Many refinements/variations have been added since Kubler-Ross' early work, but the general temporal patterning remains.

To some extent, this first approach has become disseminated into popular culture - so much so that some victims/authors have adopted "stage models" when referring to their own grief, or the grief of "victims"generally (Bard and Sangrey 1986; Riedel 1990; Young 1991: 33-9; Casarez-Levison 1992:51-5). Indeed, this tendency has become so pronounced that a noted grief counsellor wrote an article exposing, among other things, the "orderly, stage-like progression to the experience of mourning" as a common myth, stating that:

> Kubler-Ross never intended for people to literally interpret her five 'stages of dying.' However, many persons have done just that and the consequences have often been disastrous. One such consequence is when people around the grieving person adopt a rigid system of beliefs about grief that do not allow for the natural unfolding of the mourner's personal experience. We have come to understand that each person's grief is uniquely his or her own. As helpers we only get ourselves in trouble when we try to prescribe what someone's grief experience should be (Wolfelt 1989:26).

The second approach, which grew out of John Bowlby's three-volume Attachment and Loss (1969-1980), emphasizes the therapist's role in enabling the patient to accomplish tasks leading to recovery such as: (1) accepting the reality of the loss; (2) experiencing the pain of grief; (3) adjusting to the environment in which the deceased is missing; and (4) withdrawing emotional energy and reinvesting it in another relationship (Worden, 1982). Another author in this vein suggests that the therapist's role is to help the patient in the "establishment of a new equilibrium" in (i) the social world and in (ii) their relationship to "the inner representative" of the deceased (Klass, 1988:151-77).

With regard to the third approach - the common official labelling of the more severe psychological aftereffects of victimization as "post traumatic stress disorder" (D.S.M.-III-R: 309.89) - the following synopsis applies. Ostensibly, this is a medical diagnosis characterized by the following "symptoms":

> Cognitive disorders such as reexperiencing the traumatic event(s) through flashbacks, nightmares, and conditioned thoughts; heightened arousal responses such as exaggerated startle response and hypervigilance to cues of further danger; and numbing or depression with disturbances in interpersonal relationships (Walker 1992:41).

Of course, there is a long and (it seems) continually lengthening list of related diagnoses, such as dissociative disorders, self-defeating personality disorder, clinical depression, etc. Notably, when considering the diagnosis of such disorders, it must be emphasized that several authors have indicated murder to be a determinant of such "complicated grief" (Kalish 1985; Rando 1986:372; Littlewood 1992:58).

All of these approaches reflect the dominant medical model as applied to grief, have to varying degrees filtered into popular culture. Rarely, however, have they had their underlying assumptions questioned. In the first half of this lecture we will critique these formulations in four parts, with a particular emphasis on homicide bereavement:

(a) <u>Medicine as an Institution of Social Control:</u> In their examination of the medicalization of deviant behavior, Conrad (1975) and Conrad and Schneider (1980) discuss the implications of applying formal medical labels to individuals. While, on the one hand, they point out that these are related to a humanitarian trend in the conception and control of deviant behavior, remember that "even the best responses to victimization may be aversive to the victim" (Taylor, Wood, and Lichtman (1983:25). In this same spirit they have delineated seven negative implications of applying medical labels in general.

These implications are particularly relevant to victims of crime. Thoits (1990), for example, has suggested that the profound and often lengthy aftereffects of victimization may be seen as "emotional deviance." These aftereffects are often categorized, however, as a "mental disorder," or an internal psychological process following an understandable and specific course which requires professional guidance. In order to understand how applying these medical paradigms to victims of crime can have negative consequences, I will now consider the implications of the medicalization of such "deviant behavior" for victims.

First, *these labels implicitly remove responsibility for behavior from individuals in favour of their "disorder,"* creating a "dual-class citizenship" where "the not completely responsible sick are placed in a position of dependence on the fully responsible nonsick" (Conrad and Schneider, 1980:249). Thus, others are given official permission to patronize "victims" of crime, who are labelled "not responsible for their actions" due to a "mental disorder." The interactional effectiveness of "victims" is thereby diminished.

Secondly, since our society assumes the moral neutrality of medicine, then "*defining deviance as disease allows behavior to keep its negative judgement, but medical language veils the political and moral nature of this decision in the guise of scientific fact*" (1980:249). Such a characterization gives others further permission to hide their negative feelings, and even to rationalize avoidance or dismissal of "victims."

Third, there is the problem of *expert control.* As Conrad and Schneider write:
When a problem is defined as medical, it is removed from the public realm, where there can be discussion by ordinary people, and put on a plane where only medical people can discuss it...The language of medical experts increases mystification and decreases the accessibility of public debate (1980:249). Indeed, even when considering those counsellors who emphasize helping

with the tasks of coping, as in most human service, "the control stays with the professional" (Klass, 1988:185). Such an ethos may even have contributed to the lack of public debate about "victims'" issues until relatively recently.

Fourth, there is *the possibility of medical social control* of "victims" of crime. As Conrad and Schneider state: "Defining deviant behavior as a medical problem allows certain things to be done that could not otherwise be considered; for example, the body may be cut open or psychoactive medications given...This treatment can be a form of social control" (1980:249-50). Notably, such potential in the medical label may lead to further victimization of crime victims by mental health officials who are supposed to help them, and this may be rationalized as being "for their own good." For example, it has already been noted by several authors that the practice of prescribing tranquilizers, sometimes for extended periods, may ultimately delay the bereaved coming to terms with their loss (Knapp 1986:137; Rando 1986:363; Wolfelt 1987).

Fifth, there is the pernicious problem, endemic to our society, of *the individualization of social problems* (Conrad and Schneider, 1980:250). By medicalizing the behavior of "victims" of crime, we buy into this dominant ethic, and tend to search for causes and solutions to complex social problems within the *individual* instead of the social system (Klass 1988:174-7;190). By seeing the causes of the problem in the individual instead of society, we "blame the victim" when we try to change him/her instead of society. We also, in providing treatments, tacitly support existing social and political arrangements. A survivor's behavior becomes a "symptom" of an individual disease or "stage" instead of a possible statement on the nature of the current social and legal situation (Conrad and Schneider, 1980:250). Indeed, Winkel and Renssen (1998) refer to this as making *unwarranted attributions* regarding the *locus* of the victims'problems (Batson et. Al, 1982; Pelton, 1982), often inferring that the problem lies with the client when it may actually be due to some aspect of the client's social situation (Dineen, 1996; Batson, 1975; Langer and Abelson, 1974; Caplan and Nelson, 1973; Halleck, 1971; Goffman, 1961).

Sixth, and relatedly, another major negative consequence of the medicalization of "emotional deviance" identified by Conrad and Schneider (1980:250-1) is its "*depoliticization.*" By defining the behavior of survivors as indicative of "post traumatic stress disorder," or a clearly defined stage of the grief process, the meaning of such behavior in the context of the social system is lost. As such, we are prevented from perceiving it as a possible intentional repudiation of existing political as well as legal arrangements (1980:251).

Finally, there is the whole issue of the *exclusion of evil*. Conrad and Schneider state that: Medicalization contributes to the exclusion of concepts of evil in our society. Clearly medicalization is not the sole cause of the exclusion of evil, but it shrouds conditions, events, and people and prevents them being confronted as evil...Sickness gives us a vocabulary of motive that obliterates evil intent. And although it does not automatically render evil consequences good, the allegation that they were products of a 'sick' mind or body relegates them to a status similar to that of 'accidents'....it prevents us from seeing and confronting man's inhumanity to man (1980:251-2).

All of these implications are particularly relevant to the experiences of crime victims. For

example, in the case of homicide survivors consider that the professional literature suggests that "whenever reasonably possible and warranted, professional intervention following the death of a child is advisable" (Pine and Brauer 1986:88). Indeed, Victims Services programs have increasingly emphasized counselling for a wide variety of clients. Further, when one considers that, regardless of the emphasis of the treatment paradigm, "in most human service, the control stays with the professional" (Klass 1988:185), the far-ranging nature of these implications cannot be ignored.

To sum up, the application of medical labels to victims has many negative consequences. Ultimately, such labels serve to marginalize survivors into the private care of professionals "who know best"; obscure, at least partially, social influences over "victims'" actions and emotions; shield others from the political meaning of such behavior; and obfuscate the human agency involved in offenders' actions. Ironically, medicalizing the emotional aftereffects of victimization may serve as a self-fulfilling prophecy - producing the very powerlessness that the mental health profession is attempting to treat.

(b) The Unwarranted Assumption of Cultural Universality: One of the implicit assumptions underlying the medical, and particularly, the stage models of grief outlined above is, that "once triggered," there are universal "normal" stages of human grief which are independent of cultural or historical context, and which vary only in intensity, duration, and, in some models, order. As will be illustrated below, a variety of opinions exist on this point, which at least make such an assumption appear questionable, and quite possibly ethnocentric in nature.

Ezell, Anspaugh and Oakes (1987:99) take the position that "the basic experiences with grief, bereavement, and mourning are fairly similar throughout the world, but they are influenced by customs, rituals, and taboos in the various religions and cultures." Similarly, Stroebe and Stroebe (1987) argue that grief is a universal reaction, but it can be manifested variably between cultures.

A different view is held by Kathy Charmaz (1980:280-1). Denying our cultural imagery of grief as a "disease process," she states that "the extent to which loss is subjectively felt and expressed differs widely among cultural groups who experience death under different social conditions" (1980: 282-3). Following Volkart and Michael (1977), she notes that it is a particularly Western notion that "makes death a loss and grief prescriptive" (1980: 281). Indeed, she notes that some cultures consider death a happy gain for the deceased, and mourning to be inappropriate. Drawing Volkart and Michael's argument out further, she argues that culture-bound "grief expectations" do not merely underlie patterned ways of handling grief, but rather that: "The subjective interpretation of cultural meaning in conjunction with the backlog of personal experiences of the bereaved give rise to the very feelings that are defined as grief"(1980:281).

Finally, Lyn Lofland (1985:172-4) is even more critical of any universalistic elements in grief. Distinguishing the emotion of grief from the visible activity of mourning, her argument is that much of the clinical, interview, and first person account data upon which such generalizations have been based come from British and American widows, bereaved parents and widowers. Once our attention shifts away from such contemporary Europeans and Americans,

however, there is "a paucity of data" of a similar nature, either cross-culturally or historically, that "allow us direct access to others' internal feelings and private actions" (1985: 173). Thus, "because of the absence of data, the assumption of universalistic elements which is implicit in much contemporary work is at least suspect" (1985:173).

Lofland suggests rather that "an assumption of grief's variability may prove fruitful as a starting point in further research on the topic," and that "any consistency should be seen as socially problematic, a product of particular social conditions" (1985:173).

Finally, Lofland goes on to argue that grief may be "profoundly socially shaped" and "highly particularized across time and space" (1985:173; 175). She states that potentially "all aspects of the experience - its symptoms or texture, its shapes or phasing, as well as its onset and duration - (are) highly variable across space and time" (1985:175). Furthermore:

> While we do not have the requisite data on grief to document its vulnerability to social shaping, we do have data, especially from social history, on crucial experiential components. These components are: (1) the level of significance of the other who dies; (2) the definition of the situation surrounding the death; (3) the character of the self experiencing a loss through death; and (4) the interactional setting/situation in which the three prior components occur. From an interactionist perspective, it would be commonplace to assert that as these components of a death situation varied, so would human action. I want here simply to assert that as these components vary, so will human feeling (1985:175).

Given the theoretical arguments outlined above, it is, at the very least, an open question whether grief follows a universal pattern or sequence.

(c) <u>Critical Literature on the Grief of Parents and Survivors:</u> While not extensive, there has been some suggestive work on the bereavement process specific to both parents generally, and homicide survivors in particular that raises questions about simply applying the paradigms discussed above to them.

First, there is the literature, some written by survivors themselves, which emphasizes the uniqueness of their experiences. This kind of bereavement is considered different because "someone wanted him (her) dead" (Schmidt 1986; Sullivan 1992; Knapp 1986; Klass 1988). In other words, the *intentionality* of homicide creates a new dimension not found in other bereavement.

Second, there is work which indicates that the temporal uniformities characteristic of the "stage models" of grief, as well as the "tasks" that counsellors have to help the bereaved to complete, do not necessarily fit the experiences of either bereaved parents, or of survivors. For example, when any type of child death is involved, Rando (1983) has reported that the implicit assumption of the gradual lessening of symptoms over time, leading to growing acceptance of loss (i.e. "time heals all wounds") may be mistaken. Her study of general parental bereavement indicates that parental bereavement symptoms may initially subside over a period of time, then

increase again long after the death - with intense periods striking bereaved parents years after the loss (Rando 1983; Fish and Whitty 1983).

In addition, Rando (1986:56) is critical of applying Worden's (1982) model of Bowlby's "tasks" to be completed through grief counselling to bereaved parents. She argues that existing models of grief were developed in studies of widows and widowers. Thus, timetables for grieving and notions of expectable problems which are utilized by professionals are based on conjugal, not parental bereavement. According to Rando, parental bereavement has more intense symptoms and different expectable problems. Yet, "bereaved parents often will be construed as having failed to appropriately complete their grief work according to the general model of mourning currently utilized" (1986:56).

With more specific reference to survivors, Magee (1983: xiii) has observed that:

> ...the normal grief process families go through in the aftermath of the death of a family member - even sudden, early, or accidental death - a process that has certain definite stages and can be charted on a fairly reliable timetable, often doesn't apply to victims' families, whose healing is frequently disrupted by everything from community response, trials, and parole hearings to lingering images of the horror of the killing itself.

Indeed, in a study that, in part, compared the differing experiences of bereaved parents suffering the death of a child because of chronic illness, sudden unanticipated death, and murder, Knapp (1986) has noted that:

> The stage of chronic grief, initiated by the onset of feelings of loss and loneliness, is evident in only the first two of these post-death patterns. In the case of death by murder, except for the shock, numbness, and extreme despair coupled with feelings of confusion and disorganization that usually accompany an acute grief response, there is little that might be characterized as a long-term chronic grief reaction. The families of murder victims become so caught up in the complexities of the criminal justice system and the search for the guilty party that they really do not 'have the time' to grieve appropriately. There are so many intrusions into their lives by the media, by attorneys and prosecutors, and by the judicial system that they are forced to postpone the chronic phase of their grief response until later. The 'activity' that seems to fill their lives in the aftermath of these deaths leads to active grief which then becomes suspended. The feelings of loss and loneliness, and the "work" that is implied to deal with it, become postponed, sometimes for months or even years (1986:149;153).

Third, Klass (1988) has compared a well-known American support group for survivors to other bereavement support groups. In addition to the "experiential" and "interpsychic" dimensions found in other support groups, Klass has noted that, in the survivors' group, there was a "political" dimension (1988:131-35). Within this dimension, members' "powerlessness, drive for revenge, and the mazelike system of justice generate anger and rage that is far greater

and more specific than the anger associated with bereaved parents..." in other support groups (1988:131). These survivors channel their anger and rage into action to both "help each other with their ongoing problems within the criminal justice system" and to "work for reform" (1988:131).

Finally, after reviewing anecdotal and clinical psychiatric literature, and conducting a clinical study of 18 survivors who volunteered to participate in group therapy, Rynearson and McCreery (1993) have asserted that "the treatment of post-traumatic stress phenomena specifically associated with homicide takes precedence over treatment of the grief associated with the death." This is because "there is a strong therapeutic presumption that grief work must await recovery of a more stable psychological autonomy, which was overwhelmed by the overwhelming trauma of homicide" (1993:258).

It is interesting to note, however, that of the 18 individuals (14 women; 4 men) who volunteered for Rynearson and McCreery's study, two-thirds of them had antecedent psychiatric histories, and 80% were referred by therapists or support groups who did not know what else they could do. This is despite a considerable advertizing effort on the part of these researchers to attract subjects. Thus, as the authors themselves admit, their sample is biased and they "recognize that these subjects do not, in all probability, represent a normative response to homicide" (1993:259).

It is obvious from the discussion of research findings above that the experiences of bereaved parents and homicide survivors are different from those with whom the various models of grief have been developed. The experience of bereavement through homicide appears, from the limited material available, to present unique problems which require further investigation. Naturally, this raises the question of whether there may be other unique types of victimization to which these general models may be equally inapplicable.

(d) <u>The Potential Impact on Victims' Social Comparison Processes:</u> Winkel and Renssen (1998) note that while the goal of intervention has ostensibly been to assist victims of crime, thereby facilitating an improvement in their psychological condition, social psychological studies highlight a number of possible threats to therapeutic gain.

First, misperceptions by professionals are problematic (Elliot et.al., 1982; Everly and Lating, 1995; Janoff-Bulman, 1995; Sheldon, 1995), particularly the potential for them to overstate the seriousness of the victim=s psychological problem (Denkers, 1996; Dineen, 1996; Winkel, 1990, 1995; Ochberg, 1995; Vrij and Winkel, 1989).

> A victim worker who is generally expecting victims to report very serious problems due to victimization, while these problems are actually of a much less intrusive nature, runs the risk of inadvertently perpetuating, instead of overcoming, the client=s victim status (Winkel and Renssen, 1998: 204).

Secondly, like Conrad and Schneider, they argue that professionals may make unwarranted attributions regarding the locus of the victims=problems (Batson et. Al, 1982; Pelton, 1982),

often inferring that the problem lies with the client when it may actually be due to some aspect of the client=s social situation (Dineen, 1996; Batson, 1975; Langer and Abelson, 1974; Caplan and Nelson, 1973; Halleck, 1971; Goffman, 1961).

But most significantly, professionals may exhibit a bias in their expectations of clients= social comparison processes. Specifically, while it has been noted that victims can enhance their subjective well-being by comparing themselves with less fortunate others (Wood, 1996; Winkel and Denkers, 1996; Wills, 1991,1981; Winkel and Steinmetz, 1990; Agnew, 1985; Taylor et. al, 1983), support workers may expect victims to feel similar to, or to be coping less well than other victims.

> In cases of upward bias - or a lack of downward sensitivity - victim support workers tend to expect lateral (the victim saying >I=m doing as badly/well as my peers=) or upward comparisons (the victim saying >I=m doing worse than my peers=), while victims actually engage in downward comparisons (>I=m doing better than my peers=). It goes without saying that such an upward bias is a misconception, posing a serious threat to therapeutic success (Winkel and Renssen, 1998: 206).

Indeed, Winkel and Renssen conducted a study of 55 counsellors working with victims of crime and traffic accidents, finding strong evidence of such an upward bias (1998:210-11), particularly Aan overly pessimistic conception of clients@(1998: 215). However, while certainly suggestive in this regard, their study is limited in that it did not go further and examine the impact on clients themselves.

Dr. Tana Dineen (1996) Manufacturing Victims:

At this point it is appropriate for us to briefly review the controversial work of Canadian psychiatrist Dr. Tana Dineen. Dr. Dineen has been very critical of her profession, writing that it has made an industry out of manufacturing victims and ever increasing its market share. While Dr. Dineen's comments are clearly written from a strong anti-psychiatric perspective, the fact that she is writing from the inside gives us reason to at least consider the sometimes compelling arguments that she makes.

Dineen begins by stating that the term "victim" has become distorted by contemporary psychology - so much so that it seems almost impossible to distinguish real victims from those who have been fabricated. She notes that from time immemorial fate and cruelty have affected humanity, and that victims with shocking stories have existed (e.g. victims of severe earthquakes, accidents, terrorist bombings, violent sexual assaults, and, more recently, the holocaust and serial killers).The experiences of such "real" victims bring into sharp contrast the psychological practices of victim-making in far less severe circumstances.

However, Dineen argues that it is the experiences of just such victims that the psychology industry uses in order to further its own business interests. In order to thrive, it requires an ever-expanding number of *fabricated* victims. According to Dineeen, the three principles on which

the modern day mass production of victims relies are:

(1) Psychologizing;
(2) Pathologizing; and
(3) Generalizing.

Psychologizing refers to the practice of using psychological constructs to reduce real experiences to theories, thus making the external world a figment of an unconscious and highly subjective inner realm. “The psychology industry pretends to understand the unconscious, to know people better than they know themselves, and, thus, to be able to accurately interpret their experiences.”

Dineen says that psychologizing turns what individuals say about events and their effects into ideas which are very different and even disconnected from individuals descriptions. Presenting these ideas as facts, psychologists can then apply them to other people’s lives transforming virtually anyone into a victim. Psychologizing assumes as its basis an interior world in which the Unconscious has profound influence and power, a place where things are different from what they seem on the outside and can only be discovered, understood, explained, and changed with the help and direction of psychologists. It relies on the belief that, like guides familiar with the terrain, psychologists can see what is hidden there: what is not known about (the past), what can’t be seen (in the present), and what must be discovered (to achieve a better future). Psychologizing involves:

(i) Constructing a theory about victimization;
(ii) Applying that theory to individuals;
(iii) Turning personal events into psychological symbols, which are expressed in psychological language; and
(iv) Creating the need for psychologists who can interpret the symbols and cure the patient.

Moreover, according to Dineen, many of the theories constructed are developed by practicioners on the basis of their experience with patients and accepted by patients despite remaining untested by any scientific means. Yet, such clinical theories are presented as the latest, most up to date explanations of the cause of problems, and which serve to demonstrate the need for “healing” and “recovery.” It is these theories which are applied either directly to individuals who are led to believe that they suffered trauma “but don’t know it yet,” or indirectly by “experts” who speak of hypothetical cases (e.g. Karla Homolka). We have become a “psychological society” where psychologists are allowed, even expected to interpret what people say, do, and feel and to explain what their words, moods, and actions really mean at some deeper unconscious level accessible only to them. This is no more scientific than astrology, voodoo, or viewing those who “speak in tongues” as having a special gift of interpretation. By focusing on what they believe is happening on the inside and ignoring, or minimizing what is happening on the outside, psychologists say with assumed confidence “I know how you feel.” “I know what really happened to you,” etc (e.g. Satanic Ritual Abuse). These interpretations are hard to refute, and the uninitiated consumer, often seeking advice, hesitates to ask “How do you know?” So psychologists get away with applying their theories, with their psychologizing and their victim

making (*see Chart, p.39).

Dineen notes that, very early on, William James was very concerned that Freud and his followers would forget that their ideas were theories and instead would listen for material from patients that would support their psychologizing, ignoring any conflicting data. He feared that psychologists would only hear what they wanted or expected to hear, and that they would turn the experiences of individuals into a general experience whereby a patient would be equated with all other patients with "similar" problems. Apparently, this has happened, considering Dineen's recounting of how contemporary psychiatrist Robert Lifton has taken survivors' accounts of the holocaust and the bombing of Hiroshima and reinterpreted them. She notes how Lifton filters out the personal and emotional aspects of these accounts as he listens for psychological themes and recurrent patterns, and speaks for the victim. Similarly, she notes the work of Elisabeth Kubler-Ross on the psychological stages of death and dying. What has happened is that the steps intended as a model to give some descriptive understanding of the experience have been turned around by some in the psychology industry to represent psychological necessities. In other words, theories which describe an experience become the basis for determining who is a victim, and a proper treatment procedure (e.g. one who claims to be out of touch with their feelings is said to be numbed, a victim, and must have the blocks to intense feelings removed through recovering repressed memories). The unfortunate result of psychologizing is that the *personal experiences* of victims *become the clinical theories* through which *others are assessed and treated as if they are victims*. Thus, psychologizing sustains victim-making.

Pathologizing is Dineen's second principle of victim making. It refers to psychologists turning ordinary (and extraordinary) people in abnormal (seemingly unbearable) situations into "abnormal" people. This is through labelling such people "damaged," "wounded," "abused," "traumatized," incapable of dealing with it, getting over it or going on with life. Pathologizing involves assuming, looking for and emphasizing the negative, pointing to the wounds suffered, the scars left, the weaknesses and the lasting effects. It turns normal feelings into abnormal states and normal reactions under the circumstances into emotional problems. This is because the psychology industry claims the authority to deduce psychological illness and harm, to cut through to uncertainties, vulnerabilities and regrets, and to diagnose, categorize, and label human experience. This ignores or minimizes the possibility - and the potential - for traumatized individuals to cope with things, to reject the role of victim, and to move forward (e.g. the woman who had been raped that emphasized her own strength, disavowing both the terms "victim" and "survivor").

Dineen gives the example of Bruno Bettelheim, a psychiatrist who was briefly an inmate in a German POW camp (i.e. he was released before the exterminations began). He argued that all other inmates were suffering from a depressive or paranoid psychological disturbance, and that denial was merely further evidence of this (i.e. you can't win as no counter-evidence exists). Thus, all are psychologically damaged, suffer life-long aftereffects, and "survivors" need psychological treatment. These conclusions, which turned all victims into potential psychotherapy patients, have since become popularized, and the public have come to know and accept these conclusions as "clinical truths" for describing the experiences of a variety of different kinds of victims. Bettelheim's term "survivor" has been stretched to fit any and all

victims, including the manufactured ones (* see Chart, p.48).

Following Bettelheim, the psychology industry essentially views any person who has experienced a traumatic event (either real or imaginary) as suffering long-term psychopathology. Two options are presented to "victims": either to be "in denial" or "in therapy." It justifies this by playing with the notion of "normal."

In this regard, Dineen discusses how quantitative measurement of psychological attributes to discern an "average" or "normal" range have since been replaced. No longer does "normal" have to do with the common experience of people. Anxiety, apprehension, and doubt are all aspects of the life experience which may be annoying, disturbing, even something which, for the moment, disrupt living. Indeed, sometimes they may become so severe that some form of treatment is needed. But for psychologists relatively mild experiences are often seen as something more (e.g. being anxious soon turns into "being an anxious person," which soon equals "having an anxiety disorder"). Psychologists have made normal into such a narrow range that most people are, by some definition or another, abnormal:

> Today "normal" is how psychologists think the world should be: how families should function, how couples ought to "enjoy intimacy," how one ought to "resolve conflicts" without rage, yelling, or insults. It portrays the psychological image of a utopian world and defines all those without perfect lives as "victims." For if they are not normal by psychology's standard, then something is wrong; they have pathology and, according to the psychology industry, pathology is most likely the result of having been a victim."

Dineen sums up psychologists' practice with the following points, which she models on Bettelheim:

- Assuming a paternalistic attitude
- Using their own limited and sometimes unrelated experience
- Treating other people as "children"
- Pathologizing relationships
- Ignoring personal strengths of individuals
- Identifying the need for psychological treatment

Indeed, she notes a further broadening element to all this - also in the work of Bettelheim - where "the thought becomes more powerful than the act; the word more damaging than the deed; the fantasy more real than the fact. Through his approach all victims become patients and "the stage is set for all the world to become a victim."

Finally, Dineen discusses her third technique of "victim making" - *generalizing*. This practice equates the exceptional and the brutal with the ordinary and the mundane; thus ignoring the differences which set victims apart in an effort to extend and blur them with the more common experiences in life. Through this technique, the psychology industry assumes the

capacity to psychologize the mundane, using metaphor to create an absurd realm of similarities, and move down the "slippery slope" to finding victims where they didn't exist before.

She gives the example of how a group of mental health professionals during the Iran hostage crisis found difficulty in understanding how hostages felt. Thus, they took examples in their own lives where they felt like victims (e.g. break-ins, threats of divorce) and applied them. They soon lost sight of the hostages' experiences, beginning to draw dramatic comparisons between their own lives and those of the hostages. Soon experiencing a surge of empathy, they then concluded that they could empathize and understand because they shared the experience of the effects (Note: this is similar to the homicide case where a mother was upset by a former friend who stated 'I know how you feel: I had to have my cat put down').

While outlandish, Dineen says that this slippery slope logic is often employed by the psychology industry (* see Chart, p.52). Beginning with a rational thought, they descend, in gradual stages, into irrational conclusions. Dineen gives a second example of "survivor syndrome" where Lifton's concept of "death guilt," extracted from survivors of the Holocaust are applied first to physicians attending dying patients, and ultimately, to anyone who has ever seen anyone die, or known anyone who died. Ultimately, sliding down this slippery slope, through popularized ideas such as "stress" and "grief," leaves us in a position where "everything means "victim," and "victim" means nothing at all" (e.g. new categories of victims continually emerge through this process, such as "Victims of Television Violence" where individuals are seen to be as traumatized as victims of real violence).

> Years ago, children used to have a playground chant: 'Sticks and stones will break my bones but names'll never hurt me.' They knew the differences between insults and assaults. But today the psychology industry is telling everyone that an angry word hurts like a bullet and that being whistled at is like being raped. With psychologists' help, everyone can share the experiences of victims and by so doing, can come to see themselves as victims of one sort or another.

After outlining these three "victim making" practices, Dineen, in the end, points to evidence that counters these images. For example, in the case of the hostages above, it was found that, despite psychiatric predictions of lifelong emotional problems, most of the former hostages emerged to freedom without lingering symptoms, and had no problems readapting to the world. Similarly, with regard to concentration camp survivors, studies bear witness that "a not inconsiderable number were found to be well-adapted." Dineen quotes Segal, who writes that "repeatedly I have been inspired by the countless cases that run counter to experts' predictions. Instead of patterns of deficit and defeat, there is one of coping and conquest. Indeed, rather than be devastated by their suffering, many have actually used the experience to enrich their lives."

From this Dineen concludes that, while we cannot trivialize or deny the horrible suffering of victims, the fact is that some are quite capable of getting better - even thriving. What can't be condoned is stereotyping all into a common patient image: "if you are a victim, you should be a patient." Dineen feels that our mental health practitioners are predisposed by interest, investment and training to see deviance, psychopathology, and weakness everywhere they look,

and what better place to find it than in those who have obviously undergone stress? "The idea has been planted in the heads of most people that if they falter at all, doubt themselves at all, ever fear or ever fail, they lack the "inner strength," the "self-esteem," the "power" to deal with their own lives...They come to see themselves as "victims" and become "users" of the psychology industry."

My Homicide Survivors Study: Respondents' Dealings with Mental Health Professionals:

We will conclude today with a brief summary of what I observed regarding respondents' dealings with mental health professionals in my homicide survivors' study.

Subjects' experiences involved an *interaction* between the *ongoing severity of their upset*, on the one hand, and *professionals general orientations to survivors and their problems*, on the other.

I divide my comments into three categories:

(i) Information that respondents encountered re: coping;
(ii) Matters that increased or decreased their upset; and
(iii) Coping strategies that emerged by gender.

(i) Information that respondents encountered re: coping (closely linked to professionals' orientations):

- An initial *view of patient* as limited, weak and incapable of recovering on own vs. the view that an otherwise well adjusted person has suffered an upsetting tragedy;

- Poor long-term prognosis vs. good long-term prognosis *despite* initially severe upset;

- View that *individual factors* (e.g. disorders) explain lack of progress vs. the subject's *situation* explains lack of progress;

- A view that treatment can be credited with improvement vs. a view that making aware of options/practical assistance and encouragement in coping tasks can be credited;

(ii) Matters that increased or decreased their upset:

- Strong emphasis on long-term *drug treatment* vs. short-term medication at outset (dangers of numbing pain to the point of never actively dealing with it, as well as potential addiction);

- Interactions encouraging focus on horror/psychiatric labels/emotional dependence which *amplify* upset vs. careful listening/ enabling patient to *work through,* punctuated with insightful, *encouraging* comments and practical strategies (e.g. "That's normal"; "you need to communicate with your spouse");

- Narrow focus on psychological *treatment* vs. making *aware* of coping options;

- Subjects' comfort level with professional in question (affected by gender, cultural background, past breaches of confidentiality, observations of counselors in court, lack of knowledge, "offensive" advice to forgive);

(iii) Coping strategies that emerged by gender:

- Dealing with medical/psychological professionals, in one sense, is a coping strategy - one dominated by women (expressiveness, etc);

- Indeed, women engaged in therapy more often, reported being medicated more heavily and hospitalized more frequently then men;

- In another sense, however, survivors develop strategies to cope with problems they encounter with medical/psychological professionals. These include:

  - Committing crime to get quicker access to counseling (men)
  - Instead of deferring to expertise, *hedging* when in presence of therapist to make it hard to gauge reactions (both);
  - *Ignoring advice*, and increasing, decreasing, or discontinuing medication (slightly more men);
  - *Quitting* and finding another counselor (slightly more women);

In the end, there emerged evidence that, in concert with the initial severity of the problems reported by survivors, a professional's *treatment orientation* was highly significant. Those professionals with a predominantly "*individualistic*" treatment orientation tended to be most closely associated with many of the problems noted throughout this lecture. However, those with a broader orientation did not so strongly emphasize drug use and continual rehashing of negative feelings. Rather, they focused on encouraging practical solutions to ongoing interpersonal problems reflective of a more "task oriented" model of grief.