Sociology 4099: Victimology
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Overheads Week 8: Victims and the Medical/Psychiatric Profession

This week we will review and critique victims' encounters with the medical and psychiatric professions. We will proceed by:

(1) Outlining medical / psychological models

(2) Critiquing these on the following bases:

- Medicine as an institution of social control
- Unwarranted assumptions of cultural universality
- Critical literature on grief (parents/ survivors)
- Potential impact on victims social comparison processes

(3) Looking at the critical views of a noted psychiatrist on "manufacturing victims"

(4) Reviewing some of my own homicide research

(1) Medical/ Psychological Approaches to Victims:

* Three main themes:

(1) Stage models of the grieving process
(2) Therapist assisting patient to accomplish tasks/ grief work
(3) Diagnosis of various mental disorders

* Stage models:

- Rooted in work of Kubler-Ross (1969)
- Attempts to find temporal uniformities in emotional states/ behavior
- Many models exist
- Disseminated into popular culture/ many victim writers promote

* Task model:

- Rooted in work of John Bowlby
- Emphasizes therapist's role in facilitating "grief work" tasks

* Mental disorders:

- Utilizes framework of DSM to diagnose mental disorders
- Post-traumatic Stress Disorder a common diagnosis
- Categories/ list of diagnoses growing

* We will now critique these formulations, with a particular emphasis on the aftermath of homicide.

(2) General Critiques of the Medical Approach:

(a) Medicine as an Institution of Social Control

* Conrad and Schneider: Implications of applying medical labels:

- On one hand, relate to humanitarian trend (instead of blaming)

- On other hand, 7 negative implications of applying medical labels to victims' "emotional deviance." These are:

(i) Removing responsibility from individuals in favor of "disorder"
(ii) Veiling political nature of negative judgement under guise of scientific fact;
(iii) The problem of "expert control"
(iv) The potential for medical social control;
(v) The individualization of social problems;
(vi) The depoliticization of victims' behavior;
(vii) The implicit "exclusion of evil"

(b) The Assumption of Cultural Universality:

* The above medical approaches assume no variations by culture

* Theorists debate this issue:

- Ezell, Anspaugh & Oakes (1987): Similar bereavement patterns throughout world, but influenced by culture
- Charmaz (1980): Grief felt and expressed differently across cultures
- Lofland (1985): Grief's variability a better starting point

* Much existing data comes from British/ American widows. Cross-cultural data relatively rare.

* Lofland (1985): Grief "profoundly socially shaped" depending on:

(1) Level of significance of deceased
(2) Definition of situation surrounding death
(3) Character of self experiencing loss
(4) Interactional setting

* It is at least an open question whether Western medical model uniformly applicable to victims across cultures

(c) Critical Literature on Parents/ Homicide Survivors:

Researchers and victims have attacked the medical models above on the following grounds:

* "Intentionality" of death makes this experience different

* Literature suggesting that temporal uniformities and "tasks" to accomplish do not fit the experiences of:

(1) Bereaved parents generally (e.g. lessening of symptoms);

(2) Homicide survivors in particular:

- Stages/tasks disrupted by court
- No “chronic stage”
- Political dimension
- Treatment for “post-traumatic stress” vs. grief

* Experiences of bereaved parents/ homicide survivors differs from prior models in significant ways

(d) Impact of Medical Models on Victims' Social Comparison Processes:

*While goal of therapeutic intervention is to improve victims’ psychological condition, there are problems:

- Misperceptions by professionals
- Overstating seriousness of victims’ psychological problems
- Unwarranted attributions as to the locus of victims’ problems
- Bias in professionals’ expectations of victims’ social comparison processes (e.g. to similar individuals vs. worse off individuals)

* Winkel & Renssen (1998) found strong evidence of such biases: an “overly pessimistic conception of clients”

(3) <u>Dr. Tana Dineen: Manufacturing Victims:</u>

* Dineen is a Canadian psychiatrist highly critical of her profession

* Argues that term “victim” distorted by psychology: difficult to tell “real” victims from “fabricated” ones
* Argues that “psychology industry” requires expanding number of “fabricated victims.”

* Fabricated victims manufactured through three processes:

(1) Psychologizing (e.g. “Experts” interpreting unconscious)
(2) Pathologizing

(3) Generalizing

* *Psychologizing* involves:

(i) Descriptively constructing a theory about victimization
(ii) Applying that theory to individuals
(iii) Turning personal events into psychological symbols/ language
(iv) Creating the need for psychologists who can interpret symbols/ cure the patient

Essentially, the personal experiences of victims morph into the clinical theories through which others are *assessed* and *treated as if* they are victims.

* *Pathologizing* involves "authoritative" experts:

(i) Turning ordinary people in difficult situations into "abnormal" people who are "damaged," "wounded," "abused," or "traumatized"
(ii) Assuming, looking for, and emphasizing the negative (e.g. individual weaknesses, lasting effects)
(iii) Turning reactions and feelings that are "normal under the circumstances" into emotional problems
(iv) Ignoring or downplaying the possibility - and potential - for traumatized individuals to cope
(v) Identifying the need for psychological treatment

* Bruno Bettelheim: POW camps:

- Implications of term "survivor"
- Traumatized individuals are either "in denial" or "in therapy"
- Meaning of term "normal" changed from average to exceptional cases

* *Generalizing* involves "slippery slope" reasoning where exceptional/ brutal circumstances are equated with the ordinary/mundane

* Example: Iran Hostage Crisis: psychologists identified

-Their own prior feelings of victimization (e.g. from divorce, break-ins, etc.)
- Thought of hostages
- Felt empathy
- Concluded they understood

* Example: Holocaust “death guilt” progressively applied to:

- Dr’s attending dying patients
- Anyone seeing someone die
- Anyone knowing someone who died

* “Everything means ‘victim’ and ‘victim’ means nothing at all”

* Dineen provides evidence to counter these practices:

- Iran hostages: while professionals predicted lifelong emotional problems, most had few problems readapting to freedom;

- Concentration camp survivors: many were later found to be well-adapted

* While not trivializing suffering of victims, must realize that many are capable of coping, getting better, even thriving

* This runs contrary to medical view: if a victim, should be a patient

* We must be wary of the “psychology industry” predisposition to see deviance, psychopathology and weakness wherever they look

(4) <u>My Homicide Study: Encounters with Mental Health Professionals</u>:

* Subject’s experiences involved an interaction between:

(1) The ongoing severity of their upset

(2) Professionals' general orientation to survivors/ their problems

* Findings revolved around three categories:

(i) Information that subjects encountered re: coping
(ii) Matters increasing/ decreasing their upset
(iii) Coping strategies that emerged by gender

* Coping information encountered:

- Dr's view of patient (weak/ incapable vs. otherwise well-adjusted)
- Long term prognosis: (poor vs. good despite initially severe upset)
- Lack of progress (attributed to individual vs. situational factors)
- Progress (attributed to psychiatric treatment vs. making aware of options/ practical assistance)

* Matters increasing/ decreasing subject's upset:

-Long term vs. short-term drug treatment
-Focusing on horror vs. careful listening/ encouraging subject to work through in practical ways
-Narrow treatment focus vs. broad emphasis on awareness of options
-Subject's comfort level with professional

* Coping strategies emerging by gender:

- Dealing with professionals *a strategy* in itself

- Women: Engaged in therapy more often
Medicated more often
Hospitalized more often

- Strategies for *dealing with* professionals:

- Committing minor crime to get appointment (men)
- Hedging/ making hard to gauge reactions (both)

- Ignoring advice and increasing, decreasing or discontinuing medication (more men)
- Quitting/ finding another therapist (more women)

* Ultimately, along with initial severity of subjects' reactions:

- Therapist's treatment orientation found significant
- Predominantly "individualistic" therapists most closely associated with problems noted throughout lecture
- Therapists who adopted practical, task oriented approach less problematic in this sense