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The Process of Victimization

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1997

AN ESSAY PRESENTED TO THE DEPARTMENT OF PSYCHOLOGY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE B.A. WITH HONOURS DEGREE.

Abstract

This paper examines and organizes the many and varied elements of long-term victimization into one conceptual framework that explains the origin, course, and consequences of victimization. The concept was developed through clinical observations of abused patients, observations of different parenting styles and their outcomes, and a review of pertinent literature. The concept outlined in this paper incorporates various elements and manifestations of victimization into one comprehensive unit. The framework provides a basis for prediction and control of behaviour and explains some psychopathologies as defined in DSM-lll-R. This essay concludes that victimization is a process that produces a determined course of functioning by which varying experiences or stimuli are managed in a similar fashion. Exposure to the victimization process determines how information is perceived and subsequently managed by both victim and victimizer. This conceptualization of victimization provides the basis for a new approach to research into both victim psychopathology and psychotherapeutic techniques.

The Process of Victimization

Although the nature and results of victimization have been thoroughly described in the literature, few researchers have examined the actual processes involved in learning and maintaining responses to victimization. It is clear, however, that victimization is an ongoing process whose psychological impact may be felt long after the initiating interpersonal relationship has changed or minimized. For example, childhood victimization at the hands of a parent may cease when the child leaves home, however effects may continue to be psychologically manifested in many and varied ways for years to come.

Many adult psychiatric disorders are linked to childhood abuse. For example, research on borderline personality disorder consistently supports the hypothesis that childhood physical and or sexual abuse are associated with the disorder (1, 2). In addition, exposure to pathogenic parental rearing practices in childhood has been reported to be a significant factor in depression in adult women (3). Childhood physical abuse has been suggested as an antecedent to the development of combat-related post-traumatic stress disorder (PTSD) in adult Vietnam combat veterans (4), and dissociative symptoms are found to be more common among women who have suffered childhood physical and sexual abuse than among those who have not (5).

While the connections between childhood abuse and subsequent adult psychopathology have been frequently documented, the question remains: What is the interface between childhood abuse and the resultant adult psychopathology?

Theoretical Descriptions

Freud (6), in his theory of defense mechanisms, provided a descriptive theory of victimization as a progression from one role to another. In his theory of displacement, for example, Freud stated that victims of abuse shift their psychic energy from the actual abuser to a substitute and often less threatening object-catharsis. To Freud, the victim thus assumes the role of victimizer. Although this theory has been in existence for nearly 100 years, the processes or stages by which the shift of energy occurs have yet to be examined.

Seligman (7) described the primary outcome of victimization as a state of "learned helplessness." He stated that when animals or people are exposed to a negative environment over which they have little or no control, they quit responding to all environmental stimuli and behave similarly to people suffering from depression. Seligman concluded that the result of the process of victimization is depression, and that depression arises out of the expectation of lack of control over environmental conditions. Abramson et al. (8) further theorized that the attributions which individuals give to the expected lack of control are of key importance. Depressed people tend to see their lack of control as permanent, internal, and generalized over many different areas. Yet, one may ask, are there no intervening stages between the aversive condition to which the person or animal is subjected and the final state of learned helplessness?

Bandura (9) also proposed a theory which describes some types of victim and victimizer behaviour. According to Bandura's social-learning theory of reciprocal determinism, a victim's defensive behaviour may actually elicit negative reactions from

another person, a process whereby the victim perpetuates their own victimization. To Bandura, one's behaviour may actually create a victimizer in one who would not otherwise have been so. But what is the process through which this type of victimization occurs? While many descriptions of victimization exist in the literature, the processes by which it occurs are still vague and undefined.

The Clinical Experience

In the therapeutic setting, mental health-care professionals are frequently presented with victims of either an acute traumatic event or exposure to chronic physical, sexual, and/or emotional abuse. Clinicians repeatedly observe that while some patients seeking treatment suffer from severe neurotic symptomatology and, in some cases, mood or personality disorders as a result of their experiences, others who have undergone a similar trauma show fair to excellent post-traumatic adjustment with minimal intervention (10). The following case studies illustrate this phenomenon:

Mary B. is a 39 year-old successful real estate saleswoman. Following a late-night transaction, Mary left her office at around midnight and was accosted by a man in the parking lot. The stranger forced Mary into her car at knife-point and raped her. After the man left, Mary called the police and reported the incident. At the hospital, she was examined for injuries and forensic evidence and then released. A few days later, Mary sought professional help with a psychiatrist associated with a nearby rape-crisis centre. She complained of anxiety, uncontrollable crying episodes, insomnia, and depression. Her symptoms, however, were only moderately severe and responded readily to supportive therapy. After six sessions,

both she and her doctor felt that she had made considerable progress and both decided to terminate therapy with the understanding that Mary could return any time she felt she needed help. Mary went back to work within two weeks of the rape. Aside from calling the mall security guard to see her to her car after dark, she has had no lasting effects of the trauma.

The case of Isabell S., however, illustrates how different individuals' responses to trauma can be. Isabel is a 32 year-old part-time nurse and mother of two children aged 8 and 9. She lives with her husband and children in a country sub-division. In the fall of 1989, Isabell's children had left for school and she was preparing to go to work when a man entered her home and raped her. Despite her husband's insistence, Isabel refused to call the police. She felt that they would only blame her. Within two months of the attack Isabel was hospitalized for severe depression. She was unable to work, look after her family, or take part in activities which she had previously enjoyed. Prior to her hospital admission, Isabel suffered from severe anxiety and was afraid to leave her home. She became obsessed with security and had an elaborate security system installed along with numerous locks on her doors. None of these devices, however, made her feel secure and she lived in constant fear. Isabel remained hospitalized for two weeks, and is still seen weekly as a psychiatric out-patient for anxiety and depressive episodes.

This paper proposes that these two responses to trauma are due, in large part, to the degree to which these individuals have been exposed to and involved in the victimization process over the course of their lives. This paper posits that many people experience long-term, subliminal victimization from the time of childhood although the

effects of their experience may remain unconscious. Through conditioning, modeling, and reinforcement mechanisms, people gain an ability to cope with their circumstances. The efficiency with which they cope, however, depends upon several elements, such as the cognitive and behavioral position the victim assumes in relation to the victimizer, the amount of time the victim spends in that position, the feedback they experience from the position, and how victimization has taken place. This paper suggests that the victim first assumes a fighting-victim position, then an appeasing-victim position, and finally a defeated-victim position. This process may take years to transpire although others may move through the process much more quickly. Although individuals assume one victim-role primarily, through experience, learning, and reinforcement they may learn to adopt all positions. They may also learn the role of victimizer, and therefore victims may concomitantly assume the role of victimizer at any stage of the process.

The Victimization Process

Although victimization can occur any time in a person's life, the process of victimization is most easily conceptualized when one pictures parent-child interactions which begin during infancy. In this scenario, the parent holds the most power over the child's emotional, intellectual, and physical functioning. The child has relatively little power, is very needy, and depends upon the parent to fulfill all of its survival needs. If communication between the child and parent works reasonably well, both are satisfied. The parent's nurturing is rewarded with a reasonably happy and contented child.

Developmental theorists such as John Bowlby (10, 11, 12) have described in detail children's contact-maintaining behaviours with one or a few specific individuals who provide physical and psychological safety or security. The parent's willingness and ability to satisfy the child's needs creates a secure base from which the child explores his or her environment (13). Communication between parent and child must result in satisfaction of the child's needs for secure attachment to occur. The degree to which one experiences the attachment figure as reliable and responsive to one's needs defines the construct of security of attachment (10, 11, 12, 13) The child's brief forays into the outside environment, away from the attachment figure, can be perceived as attempts to satisfy their needs directly through exploration and experimentation.

In the event that communication and behaviour between parent and child do not work on a satisfying level, however, the needs of the child may be frustrated. In an attempt to remedy this situation the child intensifies its communication pattern to a level which includes whining, crying and/or screaming. In the case of an older child, temper tantrums may occur. These are fighting behaviours which result from both the frustration of the child's needs and the child's perception of the parent as the person responsible for the satisfaction of those needs. If the parent acquiesces to this level of communication, the behaviour is both positively and negatively reinforced: the child achieves fulfillment of their needs while avoiding the threat of punishment. Over time, the child learns this specific method of relating their needs to both the parent and to others in a power role. In addition, the probability that the aggressive behaviour will become automatic is increased given its early

genesis and the emotional intensity of the situation within which the learning takes place.

When the parent does not understand the child's message, they may interpret the communication as being "bad" or abnormal and administer a corrective measure such as punishment. The risk that exists at this stage of the process, however, is that the child will increase, not decrease, the level of its emotional intensity which, in turn, escalates the parent's emotional response. Thus, the cycle of reciprocal victimization begins.

The Fighting Victim

The fighting behaviour which is evident at this stage of the victimization process may become fixed and rigid due to the intractability of the parents' position and the emotional intensity and early genesis under which the learning takes place. As a result, 'fighting-victim' behaviour may generalize to many people and situations in which the victim perceives a real or imaginary frustration of their needs. As the child matures, for example, the behaviour may generalize to friends, acquaintances, institutions, society, one's self, or to anyone whom the victim even remotely perceives has the power to frustrate their needs. The way in which fighting-victims fight 'back' reflects their own experience in the victimization process.

Fighting-victims are characterized by both defensive and offensive behaviour, most clearly illustrated by their choice of language. Fighting victims' language is replete with both aggressive and overly-defensive statements such as, "It's not my fault," or "You have to fight for your rights." Fighting-victims perceive many others in their milieu as real or potential victimizers. One must note that in this generalization process, the perceived

victimizer may or may not be cognizant of their role as victimizer. The victim's perception of the victimizer as responsible for the frustration of their needs is often enough to initiate the cycle of victimization. Characteristic of the fighting-victim is the belief that the victimizer can be successfully overcome. Fighting-victims believe that their energy, means, and ability meet or exceed those of the victimizer thereby giving the victim a chance to successfully surmount the frustration that the victimizer presents. One notable difference between a fighting-victim and one who is not involved in the victimization process is that while a fighting-victim uses their energy to overcome the victimizer, one who is not a victim uses their energy to satisfy their needs directly.

When fighting-victims believe that they do not have the energy, means, or ability to fight the victimizer directly, they may fight indirectly. As in passive-aggressive behaviour, indirect fighting involves the circuitous expression of resistance or aggression to the needs or desires expressed by another, specifically those expressed by perceived victimizers. As in the case of direct fighting, indirect fighting is based upon the assumption that the perceived victimizer is in some way responsible for the satisfaction or frustration of the victim's needs.

In addition to passive-aggressive behaviour, many other psychopathologies are associated with fighting-victim behaviour. These disorders include, for example, the spectrum of paranoid disorders where the victim unrealistically perceives others as victimizers; acute and chronic PTSD where the victim engages in prolonged episodes of

combative or litigious behaviour; and antisocial and narcissistic personality disorders in which the victim displays an unrealistic sense of entitlement.

The Appeasing-Victim

In cases where, over time, repeated occurrences of fighting behaviour are not successful, the child begins to respond to frustration and punishment or its threat in the form of appeasing or apologetic behaviour. As with all victim behaviour, appeasing behaviour is acquired through behavioral, cognitive, and social-learning mechanisms, often beginning in infancy. The behaviour can be learned from a sibling, a significant role-model, or through peers. Appeasing behaviour may be both positively and negatively reinforced: apologizing behaviour may achieve the desired reward while removing the unpleasant threat or impact of the parent's emotional, intellectual, or physical assault.

Characteristic of the appeasing-victim is the overwhelming feeling that they must satisfy real or imagined conditions set by the victimizer. In order to satisfy these conditions, the appeasing-victim must assume many different roles in relation to the victimizer. For example, the appeaser becomes the good wife, the good mother, an excellent cook and housekeeper, all while holding a responsible working position. By doing so, the appeasing-victim gains an important sense of control over the environment by maintaining the power to satisfy the victimizer's needs. Over time, the sense of control as well as the ability to predict future outcomes become of paramount importance to the appeaser although prediction and control form the cornerstone of a number of neuroses specific to appeasing-victims.

Characteristic of the chronic appeaser are many classic anxiety disorders which revolve around good/bad boy/girl functioning. Some obsessive-compulsive disorders that involve checking or cleaning rituals for example, express the appeasing-victim's perceived need to maintain a pleasing or safe environment for themselves and others. Also characteristic of appeasers are chronic, sub-clinical depressive episodes in which the investment of energy in pleasing others does not produce the anticipated rewards. Over-achieving is a common trait of appeasers as is panic disorder which may occur when the victim is faced with the possibility of a discharge of their accumulated emotions. Feelings of guilt with a strong sense of accountability become apparent if something in the environment goes "wrong." These feelings represent a common phenomenological aspect of PTSD. Especially important to an appeasing-victim is the necessity to control their own feelings and needs. The chronic appeaser finds that the outward expression of needs results in their own hurt. Most often, the repression of personal needs occurs when the appeasing-victim assumes responsibility for the victimizer's needs. This responsibility then generalizes to the needs of others in their milieu. An appeaser tends to nurture everyone in their environment but does not give equal time to the satisfaction of their own needs. Their behaviour is reflected in their use of language which is filled with statements such as, "I'm sorry," or "I'll leave it up to you," or "Whatever you want is fine with me."

The Defeated-Victim

If, over time, appeasing and apologetic behaviour do not produce escape or avoidance of punishment, the child may stop responding altogether. This behaviour, too, will

often stop parental punishment, however this stage of the process indicates that the child is essentially defeated. The primary essence of survival to a defeated-victim is reduced to the physical level at the expense of fulfillment of other emotional, intellectual, and/or physical needs. The victim believes and accepts that there is no escape from hurt, regardless of what they do. These beliefs result in passivity towards the environment and are expressed in disorders such as depression, dysthymia, alexithymia, avoidant and dependent personality disorders, and dissociative disorders. Defeated behaviour is most commonly associated with victimization because its symptoms are so broadly recognizable. Depression, primarily through the work of Seligman and learned helplessness, is well-understood as the behaviour of one who has given up on the environment

Characteristic of defeated-victims are feelings of powerlessness and chronic sadness. They feel that their lives are empty. They also exhibit a powerful and constant inhibition of feelings such as anger. To the parents of a defeated child, however, the characteristics may be highly acceptable. The child is malleable, quiet, and apparently not very needy. Their language is replete with self-abnegating statements such as, "Whatever you want," or "I don't care." The parents and the environment may reward this behaviour although such reinforcement causes the behaviour to become fixated. The behaviour, therefore, may remain long after its adaptive value subsides. Figure 1 summarizes the variety of parent-child interactions and their results.

The Victimizer

Although the process of victimization is most easily conceptualized using

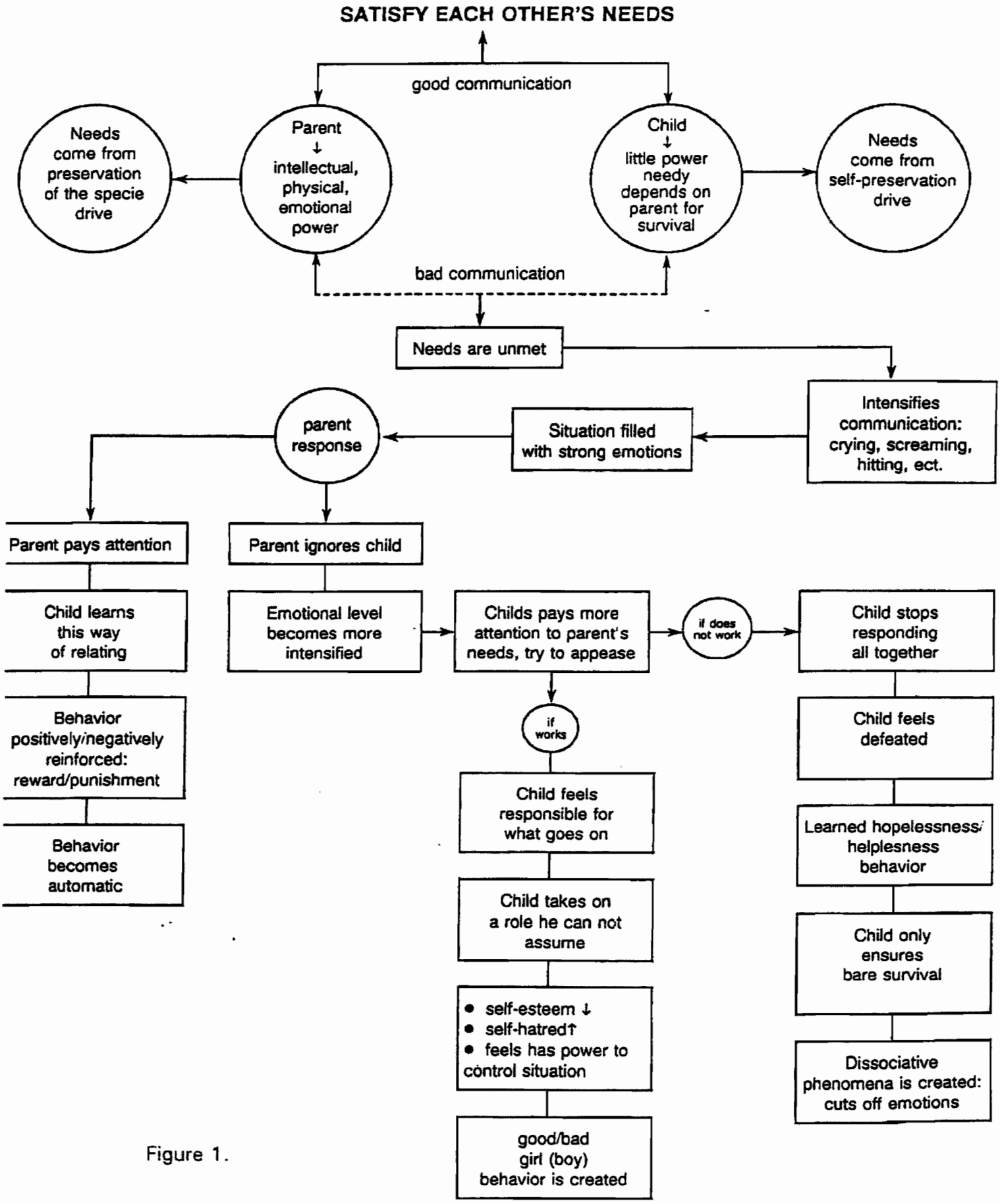
SATISFY EACH OTHER'S NEEDS
good communication
Needs come from preservation of the specie drive
Parent ↓ intellectual, physical, emotional power
Child ↓ little power needy depends on parent for survival
Needs come from self-preservation drive
bad communication
Needs are unmet
Intensifies communication: crying, screaming, hitting, ect.
Situation filled with strong emotions
parent response
Parent pays attention
Parent ignores child
Child learns this way of relating
Behavior positively/negatively reinforced: reward/punishment
Behavior becomes automatic
Emotional level becomes more intensified
Childs pays more attention to parent's needs, try to appease
if does not work
Child stops responding all together
if works
Child feels responsible for what goes on
Child takes on a role he can not assume
• self-esteem ↓
• self-hatred↑
• feels has power to control situation
good/bad girl (boy) behavior is created
Child feels defeated
Learned hopelessness/ helplesness behavior
Child only ensures bare survival
Dissociative phenomena is created: cuts off emotions

Figure 1.

parent-child interactions, the process may occur any time one person has little power and is relatively needy and another person has relatively more intellectual, emotional, and/or physical power. The victimizer may be a person, an object, an institution, an idea - anything or anyone who has the power either to hurt the victim or to satisfy some of their needs.

In their research on "traumatic bonding," Dutton and Painter (15) revealed two particularly salient features that characterize the victimizer from the victim's perspective. The authors state that the relationship between abuser and victim "is formed on the basis of two features of the social structure between batterer and victim: an unequal power relationship and an alternation of abusive with more positive social behaviour" (p.363). The victimizer, therefore, may be anyone in the victim's milieu who has intellectual, emotional, and/or physical power in excess of the victim's. Also, according to Dutton and Painter, the victimizer has the power to intermittently provide the victim with some rewards. Implicit in this concept is the idea that the victim feels somewhat unable to satisfy their own needs directly and must rely upon the victimizer for reinforcement.

From Victim to Victimizer

Research consistently indicates that victimizers have been victims in one or more of their earlier relationships (16,17,18,19). The transformation from the role of victim to victimizer is a complex aspect of the victimization process in which the victim either consciously or unconsciously assimilates the role of victimizer. The manifestation of this learning may remain latent or it may be expressed in behaviour. For example, the victim may occasionally act out the role of abuser by victimizing a younger and less powerful sibling or

pet. Or they may simply assume the role cognitively wherein the manifestation remains purely intrapsychic. The frequency and intensity of the outward expression of their own victimization depends upon many factors including the emotional intensity under which their learning occurred, the number of stimuli they associate with their victimization, the reinforcement achieved by their acts, and the length of time they were exposed to the victimization process. However, the role may remain latent until a situation and/or relationship arises which is in some way reminiscent of their own victimization. These stimuli may then elicit a victimizer-role response

Many researchers' observations fit well with the learned-role aspect of the victimization process. For example, Burgess et al. (18) theorized that the victim's cognitive role-playing may be a defense mechanism with which to handle the stress of abuse. In their article Abused to Abuser: Antecedents of Socially Deviant Behaviors, they state: "Major cognitive operations necessary to process and manage distress develop" (p.1436). They go on to say that when victimization occurs in childhood, "The youth's denial of his position of vulnerability and helplessness as a victim enhances identification with aggression. This reformulation of the actual trauma experience creates the link from abused to abuser" (p. 1436). The learned-role component of the victimization process, therefore, may be seen when the victim cognitively assumes the role of abuser as a denial of their own role as victim. Implicit in this concept is the notion that to assume the role of victimizer, one must first have assimilated the role from one's milieu.

Discussion

The concept of victimization as a process encompassing stages and roles provides a conceptual interface between abuse and psychopathology and, therefore, it fits well with current research in abuse and its aftermath. Findings in borderline personality disorder, PTSD, and depression, for example, are easily understood using the principles outlined in this conceptualization. The theory states that once a victim-role is induced through behavioral, cognitive, and/or social-learning mechanisms, the role remains relatively fixed over time. The corollary to this statement is that stressors encountered in adulthood exacerbate the characteristics of the victim-role learned over the course of the victimization process.

The argument that the victim-role remains relatively fixed over time is supported by current research into PTSD. For example, in their investigation of the relationship between childhood physical abuse and PTSD, Bremner et al.(4) note that men who were abused as children are more likely to suffer from combat-related PTSD. Severe abuse experienced in childhood leads to appeasing- and/or defeated-victim positions. According to the victimization process, men who were abused during their youth respond to war according to the victim-role that they assumed in relation to their previous victimizer. Although much research is needed to verify that the adult PTSD victim's position is appeasing and/or defeated, the victimization process construct provides a clear and concise conceptual framework from which to investigate this phenomenon. Another area currently of interest to researchers is depression in women which may take a number of forms. Depression may appear as reactive where symptoms of sadness and anxiety are clearly linked to a precipitating

event in the person's environment. This type of depression is quite short-lasting and responds well to therapy. Another presenting form of depression involves feelings of guilt, chronic emptiness, fear and anxiety. Major depression is characterized primarily by extreme passivity, feelings of hopelessness and helplessness, and may include symptoms found in other types of depression such as guilt and emptiness.

In their research into an integrated etiologic model of major depression in women, Kendler et al. (3) found that stressful life events were the strongest predictors of liability to major depression. Other predictors include previous history of major depression and neuroticism. According to the victimization construct, major depression indicates the defeated-victim position of functioning. Once defeated behaviour becomes relatively fixed, its characteristics will become more salient in response to either a single stressful life event or a series of events which may occur in adulthood.

Much research is being done in borderline personality disorder (20). Findings continually support the notion that childhood abuse, particularly physical and sexual abuse, is associated with the disorder (21). The victimization process framework conceptualizes borderline personality disorder as the rapid cycling, by the victim, through all three of the fighting, appeasing, and defeated modes. The nature of the trauma suffered in childhood by borderline patients requires these individuals to learn and become competent in all victim-roles as well as that of victimizer. The chaotic nature of the outcome can be seen as a compilation of victim-roles and a generalization of victimizer status to almost anyone in the environment, including themselves.

Gunderson and Sabo (22) examined the phenomenological and conceptual interface between borderline personality disorder and PTSD and state that there is "considerable phenomenological overlap in the ways that both PTSD and borderline personality disorder can present" (p.22). The authors further state that "although 38% of the population is exposed to catastrophic stress, only about 9.2% ever experience a PTSD-like reaction" (p.22). Also, "PTSD is more likely to occur in individuals who have had previous exposure to unusual stress or who have maladaptive coping mechanisms and other adjustment problems" (p.22). Gunderson and Sabo's observations may be seen as evidence that victims assume a fixed position in relation to their environment. Those victims who did not suffer abuse in childhood or early adulthood do not reach the appeasing and/or defeated stage of the process and, therefore, respond to victimization from a fighting or self-satisfying position. Healthy or fighting-victims cope relatively well with catastrophic stress and exhibit far less psychopathology than do appeasing and defeated victims. Fighting and healthy individuals account for the number of people who do not suffer PTSD-like symptoms after a catastrophic event. However, due to their role in the victimization process appeasing- and/or defeated-victims do suffer from PTSD as a result of stress.

Management

Several principles should be respected when dealing with either acute or chronic victimization. Ochberg (23) outlines the following:

1. Support.
2. Modulation of work and activities.

3. Facilitating sleep.
4. Awareness of cognitive impairment and risk of injury as a result.
5. Need for empathic listening.
6. Educating the patient about the stages of stress recovery.
7. Low pressure during denial phase.
8. Structuring time-limited therapy if the trauma is not too extreme and/or complicated by a personality disorder.
9. Unlimited-time therapy for certain chronic stress syndromes.

The process of victimization construct theorizes that victims are individuals who depend upon others for the satisfaction of many of their needs. Therefore, the most successful management strategy involves instructing the victim (and the victimizer) how to satisfy their needs openly, directly, and economically. Some individuals, particularly those who function predominantly as defeated-victims, are not even aware of what their needs are. The needs have been repressed for so long that clarifying those needs is a major undertaking to both therapist and client. Also, appeasing-victims are unaware of their own needs because of the emphasis they place on the needs of others. Appeasers consistently need to be asked, "how do you feel?" or "where do you fit into this?" in order to connect with themselves more directly.

Fighting-victims focus much of their energy on real, potential, or imaginary dangers to themselves. Their problem-solving is consistently related to the perceived threat that others pose to them and their well-being. They also spend very little time examining

what they need and how to achieve those needs directly. Although fighting-victims are better equipped to fulfill their needs than either appeasing- or defeated-victims, those fighters whose position is extremely fixed and rigid often antagonize those in their environment. They thus engender a great deal of animosity, yet are baffled by others' hostility

The process of therapy must begin with a therapeutic environment where the patient can safely open up. Victimization is initially recognized in terms of its consequences. For example, the phenomenological element of re-experiencing associated with PTSD is a common consequence of a traumatic experience. In therapy, the patient is given the theoretical aspects of the victimization process and the victim-role that they play within it. Clinicians repeatedly convey that their clients are both enlightened and relieved when the process of victimization is explained to them. For the first time, the victim can put victimization, their own and others' behaviour, into a meaningful context. This new understanding allows the victim to reach a validation of themselves which in turn enables them to create a foundation on which to build a happier and more meaningful life.

Therapy for victims is also a process that involves bringing the patient back through the roles they have learned throughout the victimization process. For example, a defeated-victim has experienced all three victim-roles and must be encouraged to re-experience their victimization, with insight, from the defeated position through the appeasing position to the fighting position. Clinicians repeatedly report, however, that the fighting-victim position presents some difficulty. Therapists may unconsciously influence the patient to revert to either an appeasing or defeated position because the fighting-victim role does not

fit the safe reality of the therapeutic environment. The therapist's (and society's) negative feedback to the fighter tends to turn the patient back into appeasing or defeated modes. This difficulty may be remedied, however, by therapeutically introducing the patient to safe ways of fighting by using techniques such as role-playing.

With insight into the properties of victimization as a process, victims' re-experiencing will occur almost naturally. This natural progression through the stages is a consistent observation and may reflect the victim's need to discharge the emotional energy they have accumulated at each stage of the process. Once the fighting-victim position is achieved, the step to 'healthy-victim' status is relatively easy to attain. A healthy-victim is one who is able to meet their own needs openly, economically, and directly. Many individuals do function very well from a blend of healthy-fighting positions. These people are aware of their needs, have the ability to fulfill them, and will only oppose others when the situation truly warrants.

Conclusion

The victimization process framework states that victimization occurs through a series of interpersonal interactions in which one person has little power and is quite needy while a significant other person in their environment has relatively more intellectual, emotional, and/or physical power. In the victimization process, the victim progresses through victim-roles in the descending order of fighting-victim, appeasing-victim, and defeated-victim. Through victim therapy, the therapist guides the victim back through the stages which

they have learned until the victim has the strength to satisfy their own needs directly. The individual is then healthy enough to remove themselves from the victimization process.

This construct emphasizes three fundamental elements: the victim, the victimizer, and the conditions under which victimization occurs. Although the process of victimization may occur at any time in a person's life, childhood victimization produces the most rigidly fixed victim-role due to the early genesis and emotional intensity under which the learning takes place. The power of early-learned reinforcement is also a factor which strengthens any victim position. Thus, the victim-mode with which the individual has the most experience and reinforcement will become most salient when they experience chronic stress, abuse, or a traumatic event in adulthood. Victim positions do represent individuals' general orientation to life. The theory gains its prognostic value when the therapist determines the primary mode from which a patient functions, the length of time spent in that position, the flexibility of the position, and the conditions under which victimization has occurred.

Future Research

The concept of victimization as a process stimulates both future investigation and inventory design. For example, as a theoretical concept, it requires concrete diagnostic tools. A questionnaire must be designed that will assist in quantifying and diagnosing aspects such as the victimization process as a progression from one role to another. For example, when and under what conditions does the transition occur? And, can transitions be predicted?. Also, what is one's current position in the process, the rigidity of the position, and the (mal)adaptability of the position.

A second area of investigation should involve a study of the language associated with each victim position and how this language impacts personal interactions. This area of research will be especially interesting to family therapists, particularly those who follow the "process-model" work of communication humanistic therapist Satir (24).

A third point of inquiry must focus on the individual's vulnerability to victimization. Do genetics play a role in vulnerability? Is there a biological component which mitigates environmental influences? The work of van der Kolk (17) will be of interest in this area. Fourthly, what role does gender play in maintaining the victimization process on a broader sociological level? Does a history of patriarchy account for the fact that females are more likely than men to be abused in our society ? (19) If so, what changes in social structure might society consider?

The concept of victimization as a process encompasses human functioning at a variety of levels over the course of the life-span. This concept organizes elements of long-term victimization into one conceptual framework that covers the origin, course, and consequences of victimization while incorporating various elements and manifestations of victimization. This paper concludes that victimization is a process producing a determined course of functioning by which various experiences are managed in similar fashion. Exposure to the victimization process determines how information is perceived and managed by both victim and victimizer. This conceptualization of victimization provides the basis for a fresh approach to research into both victim psychopathology and psychotherapeutic techniques.

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