**SOC 3120 Social Psychology**

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 **Lecture 19: Deviance and the Social Order 1I: Variable Responses to Similar Acts**

 Now that we have introduced the relevance of deviance for the social order, introduced and critiqued the traditional objectivist approach, and begun to outline an interactionist conception of deviance, it is time to elaborate the key issue of variable responses to similar acts.

 The interactionist perspective on deviants relies on the premise that the meaning of an act as deviant or not is contained in the social response it gets rather than merely in the act itself. This is an extension of the basic S.I. position that objects take on meaning according to how people act toward them, and deviant acts are objects of concerted definition and action by audiences, whether formal agents of social control or people in everyday life.

 Thus, what is true of all acts is also true of deviant acts: any act lends itself to a great variety of interpretations, depending on the context of the act and the imputations others make about it. Are a group of teenagers driving around in a fancy car simply out enjoying a drive and some socializing, or are they joyriding in a stolen car? The meaning of such acts depends in part on the intentions of the actors, but it is also a function of how observers act toward them and how acting persons then respond.

 Given this basic perspective, it becomes important to determine the general processes at work in defining the acts of particular individuals in particular cultures as deviant. Two basic questions arise:

(1) Why are some acts and not others perceived as possible breaches of social order and treated as reasons to single out individuals and impute negative characteristics to them?

(2) Why are the acts of some individuals apparently more likely to be regarded as deviant than those of others?

 With regard to the first question, we may consider the issue of when social norms are (or are not) invoked. Some forms of conduct may be so universally perceived as willful breaches of social order that traditional normative conceptions invariably grow up around them. The taking of human life, for example, may be perceived as a fundamental threat to social order in any society. We could argue that a sense of outrage at homicide is a natural, existential response and that the development of norms and rules against it is thus a natural phenomenon. This approach has something to recommend it, as, even though all societies find exceptions to this rule (e.g. enemies), the act itself seems inherently a threat to social order.

 It is more difficult, however, to see the definition of any act as deviant in the same way - particularly once we move beyond violent behavior against persons. In order for theft to constitute deviance, for example, there must be a fairly specific conception of property rights - normative conceptions of who owns things and has the right to use, move, destroy or otherwise dispose of them. If the social order is founded partly on beliefs that individuals are entitled to enjoy private property (e.g. the U.S.), then a perception of theft as a breach of order is natural for that society. In societies where property is shared freely among the members of a community, theft cannot by definition exist as a form of deviance.

 **Moral Enterprise:**

 If we move beyond types of deviance over which there is widespread agreement (e.g. murder, theft, violent crime and mental illness), there lies a far more ambiguous realm of rules, categories of deviance, and perceived breaches of social order that we cannot as readily account for. Delinquency, for example, does not seem to naturally flow from the basic conditions of human existence - indeed it is a relatively recent social invention. Similarly, while Rosenberg’s approach to mental illness (e.g. as behavior where observers are unable to role take) introduces some order into the nature of insanity as a folk judgement, mental illness is likewise a relatively recently created social category (e.g. it was once seen as a moral failing, a weakness, punishment for sin, or conceptualized supernaturally as “having a demon”).

 Why are such categories invented? To speak of them as inventions does not suggest that the behaviors to which they point did not in some form already exist. Juveniles do occasionally engage in thoroughly bad conduct. Some people do have such major difficulties coping with life that the category of mental illness seems well-suited to them. These kind of behaviors exist, but they also exist in part because a category exists into which we have learned to classify them, in terms of which we have learned to think about them, and to encourage those who commit them to think about them. Why?

 A fundamental insight of S.I. has been that the creation of deviance categories as well as the making and enforcing of rules against various forms of conduct results from both individual and collective enterprise. Categories and rules do not emanate fully formed from culture. They don’t just magically appear. Rather, rules are the result of collective efforts of definition and redefinition of right and wrong by those whom Howard Becker termed “moral entrepreneurs.” Becker illustrated this through the example I discussed in class last week, the intensive lobbying by the Federal Bureau of Narcotics seeking passage of the Marijuana Tax Act in 1937. Officials of the bureau sought to bring marijuana within their official jurisdiction (hence the focus on heavy taxation), so they waged a sustained public relations campaign in order to gain congressional support. This campaign was ultimately successful not only in securing legislation (and funding), but also in widely publicizing the alleged dangers of the drug.

 It’s important to recognize that before the bureau’s campaign, law enforcement officials had expressed little concern about marijuana, and few states had laws prohibiting it. There was no widely perceived breach of social order in the use of this drug until a group of moral entrepreneurs - motivated as much as anything by a desire to see the powers and budget of their bureau expanded - succeeded in creating such a public perception. The evils of the drug were dramatized, rules against its sale and possession formulated, and the perversities of its users highlighted - not because of the spontaneous responses of people to an obvious breach of order, but because of moral enterprise.

 Similarly, in his analysis of the American Temperance Movement, Joe Gusfield showed that such moral campaigns are closely related to how the constituent groups of a society view one another. Rural Protestants, who had traditionally dominated U.S. culture and upheld temperance norms, began to feel more and more threatened by urban, Catholic, working-class immigrants as the 19th century wore on. Increasingly, they turned their attention away from a humanitarian concern for the victims of alcoholism toward a more combative, coercive effort on behalf of the prohibition of alcohol. The use of alcohol became seen as a violation of the Protestant conception of moral conduct and a practice with unfortunate consequences, as well as a potent symbol of the decline in status and influence of the older Protestant groups relative to those of newcomers. The successful passage of prohibition provided a way for Protestants to symbolically assert what they felt was their legitimate “moral ownership” of U.S. society in the face of their actual declining status and power.

 Such moral enterprise is by no means a phenomenon confined to past eras. In recent years moral entrepreneurs have focused their attention on a wide variety of social problems (e.g. ADHD, child abuse, elder abuse, family violence, second-hand smoke, etc.) Often the motives that underlie efforts to arouse public concern about a form of deviance seem to have little to do with the conduct itself. The news media, for example, discovered the “crack epidemic” in the late 1980's, precipitating, along with politicians, the “war on drugs.” While there can be little doubt about the negative effects of crack, the reporters who publicized the problem probably did so before the use of crack drastically increased rather than after. Was it concern for the welfare of crack users that motivated such entrepreneurs, or selling newspapers and getting good ratings? Was crack defined as a serious form of deviance because of its objective threat to social order, or because it came to symbolize the perceived threat to social order embodied by urban, poor, minority sellers and users? Did politicians really seize on the drug issue and associate it with a stigmatized group as a way of mobilizing political support?

 Such examples suggest that definitions of deviance, like social problems more generally, may often be the product of the actions of specific individuals and groups with goals that go well beyond the particular form of deviance in question. In such cases, threats to the social order are either manufactured to serve the interests of particular groups and organizations as with the Federal Bureau of Narcotics, or seized on as a way of providing symbolic support for the values and social standing of groups that feel threatened, as in the case of rural Protestants and their campaign for temperance.

  **Mental Illness:**

 Mental illness is another illustration of conduct where we can easily grasp why a sense of concern about social order is aroused. Morris Rosenberg argues that S.I. enables us to zero in on what it is people find unusual about at least one form of mental illness: psychosis. Rosenberg says we call certain behavior “insane” because we are unable to grasp the perspective from which the person exhibiting the behavior has acted - our efforts at role-taking are unsuccessful - and we attribute this failure to the other’s conduct and not to our own inability or unwillingness to try and understand it.

 Rosenberg goes further, arguing that the criteria psychiatrists use to identify psychosis - although sound and useful from a medical point of view - don’t really tell us much about why we find psychotic behavior disturbing. While psychiatrists rely on individual criteria such as “subjective distress” and “impairment of functioning” to diagnose various forms of mental illness, it is important to recognize that people in many circumstances experience subjective distress or impaired functioning but are not considered mentally ill. Many people suffer unfortunate tragedies in their lives, become upset and don’t function as they normally would - yet we do not consider them psychotic. In fact, we may consider such reactions quite “normal” under the circumstances.

 Yet, mentally ill people clearly do exhibit stress and impaired functioning. The psychiatric view tends to treat their behavior, thoughts and emotions as objective symptoms of illness. The problem here is that behavior that under some conditions is treated as evidence of psychosis is viewed entirely differently under other conditions. For example, a wealthy movie star arrested for shoplifting could be diagnosed with kleptomania; a poor youth living in a slum doing the same thing could be considered sane, and the behavior as a wilful act. If conduct under the former circumstances is considered symptomatic of mental illness, but not under the latter, then what makes the act sane or insane is not the act itself but rather the way that others interpret it. The same goes for things like belief in ghosts or angels in a culture that does not favor such views, or depression following bereavement vs depression for no apparent reason.

 Whether behavior, thought or emotion is regarded as “sane” or “insane” depends on whether and how an observer makes sense of it. We cannot understand why a wealthy person would shoplift, whereas we can understand such motivations of the poor. In the former case we cannot successfully role-take - we cannot impute any perspective or motives to the other enabling us to see the conduct as an expression of the person’s role. In the latter case, we can more easily do so (e.g. out of necessity to meet one’s basic needs). Similarly, we can recognize a reason for the depressed person who has recently suffered a bereavement, but find it harder to understand why someone is depressed for no apparent reason. Thus we are predisposed to invent one - becoming inclined to see their depression as an indication of mental illness.

 Of course, failure at role taking does not inevitably lead us to view the other’s conduct as indicative of insanity, but only when we believe that the failure is not our own fault (e.g. we don’t consider babies or the behavior of doctors insane, even though their behavior is often quite hard to fathom). Rather, we just assume that we just have not been able to figure out why they behave in a certain way, or take certain unfathomable actions.

 Yet under some conditions, we attribute our failure of role taking to the behavior of the other rather than to ourselves. Where we think we should observe conduct that is typical of an individual as a role incumbent, and where the behavior we observe seems atypical, improbable and inexplicable, then we are likely to impute that the fault lies with the acting person. If one’s spouse becomes depressed and we cannot explain it in terms of his personality, experiences, or circumstances, then we often start to think that something is wrong with him. We may not immediately jump to the conclusion that he is mentally ill, but we at the very least become suspicious that something may be amiss - and that the problem lies with him rather than us.

 Rosenberg’s approach to mental illness fits in well with the general approach to deviance developed last class. That is, social suspicions or judgements of mental illness seem to focus on the individual whose behavior is in question and they seem to attribute to that person a special and not very positive status. While it is the puzzling behavior that is noteworthy, once we start to consider this insane, so do we the person in question. Mental illness, like other forms of deviance, is a label that comes to apply to the whole person and not just the behavior. Once that happens, all of the negative stereotypes - such as unpredictability or violence - associated with mental illness become attached to the person.

 Moreover, not only do we attribute a deviant being to the person as a way of accounting for his/her conduct, but also a sense of threat to social order is mobilized. It’s difficult and uncomfortable to deal with people when we cannot successfully role take. Our normal expectations about how people will behave are not met, so there is a sense of discomfort - and often a sense of more serious threat. People who address us in a babble of incoherent words or seem depressed for no reason disrupt our usual assumptions that we are living in a world where people understand one another and interact in an orderly fashion. Indeed, because stereotypes have grown up about the behavior of the mentally ill (e.g. dangerousness, violence), there is also a deeper sense that we might be harmed if they are not isolated and controlled.

 **Jim Stolzman (2000): Social Dimensions of Mental Illness:**

 Here, I sum up in point form recent sociological work on mental illness as described by Jim Stolzman:

\* Although it is customarily viewed as a psychological and /or biological phenomenon, mental illness also has many social dimensions.

\* Psychiatric conceptions of mental illness emphasize that it is a pathological condition of the body unaffected by what either the individual afflicted or other people think and feel about it. Sociologists argue that mental illness is also a social state based on cultural standards of normality and evaluations of other people that carry consequences for how people defined as mentally ill are treated.

\* Biomedical views of mental illness arose historically as a reaction to theological conceptions of madness, which viewed the mad as wicked sinners in the grip of supernatural forces. Medicine’s authority as the agents in society responsible for mental disorder derived more from the key role physicians played in reforming mental asylums than from the scientific superiority of their ideas and treatments. The recent drug revolution in treating mental disorder was instrumental in winning public acceptance of the medical model.

\* The anti-psychiatry movement of the 1960's and 1970's challenged the conceptual integrity of the psychiatric enterprise. Psychiatry has attempted to minimize diagnostic bias by emulating the scientific procedures employed in other areas of medicine. The viability of this strategy is questioned because it neglects the influence of contextual factors in psychiatric assessment.

\* The way society reacts to certain kinds of unusual behavior may or may not result in designating them as “mental illness.” Such labeling can lead to a transformation of identity and an adoption of the social role of mental illness. The stigma attached to the label of mental illness has negative consequences, but the labeling perspective overestimates the extent to which the process is self-fulfilling and underestimates the extent to which psychological impairment is a reality independent of social definitions and reactions.

\* Sociological analysis seeks to explain variations in the rates or social patterning of mental illness. Psychological analysis, in contrast, addresses the question of why some individuals are mentally ill while others are not. Many of the established patterns of mental disorder appear to reflect the amount of stress associated with different social positions. Two macro-level sources of stress have been identified - namely, socially structured inequality and socially structured ambiguity. Social positions that are low in the status hierarchy or provide their occupants with conflicting expectations and demands are associated with high levels of stress.

\* Analysis and empirical inquiry into the connections between social stress, psychological distress, and mental disorder are required to specify under what conditions social stress does or does not translate into psychological distress and the latter does or does not develop into mental disorder. People’s vulnerability to stress and distress is not only a matter of their personal characteristics; it is also affected by social location and features of their social environment.

 **Conrad and Schneider (1980): Medicine as an Institution of Social Control:**

 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, they have delineated seven negative implications of applying medical labels in general.

 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 those who are labelled "not responsible for their actions" due to a "mental disorder." The interactional effectiveness of such individuals 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 such individuals.

 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).

 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 victimization of individuals by mental health officials who are supposed to help them, and this may be rationalized as being "for their own good."

 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 person’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 individual’s 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 individuals’ behavior as indicative of an illness or disorder, 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).

 To sum up, the application of medical labels has many negative consequences. Ultimately, such labels serve to marginalize individuals into the private care of professionals "who know best"; obscure, at least partially, social influences over individuals’ 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 problematic situations may serve as a self-fulfilling prophecy - producing the very powerlessness that the mental health profession is attempting to treat.

  **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 practitioners 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.”

 In the next class we will conclude this chapter by considering two final topics: (1) the causes of deviance; and (2) deviance and identity.