

# *Attitudes to Victims: Issues for Medicine, the Law and Society*

ALEXANDER  
MCFARLANE

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## **Society's Ambivalence Towards Victims**

A central concern of any legal system should be to protect the rights of victims and to deliver them justice. Yet society is always ambivalent about the rights of, and its obligations to, the weak, the injured and the disenfranchised. This is particularly the case when victims claim to be psychologically damaged by their experience and ask for compensation or support. Historically, these prejudices probably have been most openly expressed in society's management of and attitudes to war veterans and individuals seeking compensation for 'nervous shock'. For example, the ambivalence of the military in the First World War about how to deal with soldiers suffering from shell-shock is indicated by the fact that some claiming to suffer this condition faced the firing squad, accused and convicted of cowardice. The issues are conveyed in this quotation from *Death's Men* by Dennis Winter (1978), a book about World War I based on men's diary accounts. In this incident, the soldier to be executed by his comrades had previously fought with courage.

*A man was shot for cowardice. The volley failed to kill. The officer-in-charge lost his nerve, turned to the assistant provost marshal and said 'do your own bloody work, I cannot'. We understood that the sequel was that he was arrested.*

*Officially, this butchery has to be applauded, but I have changed my ideas. There are no two ways. A man either can or cannot stand up to his environment. With some, the limits for breaking is reached sooner. The human frame can only stand so much. Surely, when a man becomes inflicted, it is more a case for the medicals than the APM. How easy for the generals living in luxury, well back in their chateau, to enforce the death penalty and with the stroke of a pen sign some poor wretch's death warrant. Maybe of some poor, half-witted farm yokel, who once came forward of his own free will without being fetched. It makes one sick (Evans, in Winter 1978, p. 140).*

This quote raises the constant tension about how medicine should conceive of the victims of trauma. Many medical writers of the time saw these men as suffering from ‘moral inferiority’, they were ‘moral invalids’. In this light these men did not deserve the status of patients but rather warranted dishonourable discharge or court martial (Winter 1978). This attitude contrasts to the evocative description by Sassoon of the suffering which these men endured. Sassoon had distinguished himself for bravery in combat and his war poetry (Herman 1992).

*Shell shock. How many a brief bombardment had its long-delayed after-effect in the minds of these survivors, many of whom had looked at their companions and laughed while the inferno did its best to destroy them. Not then was their evil hour; but now; now, in the sweating suffocation of nightmare, in paralysis of limbs, in the stammering of dislocated speech. Worst of all, in the disintegration of those qualities through which they had been so gallant and selfless and uncomplaining—this, in the finer types of men, was the unspeakable tragedy of shell-shock . . . In the name of civilisation these soldiers had been martyred, and it remained for civilisation to prove that their martyrdom wasn't a dirty swindle. (Sassoon, in Fussel (1983), p. 141).*

The attitudes to the suffering of the victims of war were little different in the second world war. These are provocatively described by Germaine Greer (1994) in *Daddy, We Hardly Knew You* which is based on her reflections about her father's war experience and his traumatic neurosis.

*When [the medical officers] examined men exhibiting severe disturbance they almost invariably found that the root cause in pre-war experience, mostly 'domestic'. This strengthened them in the belief that the sick men were not first-grade fighting material . . . The military proposition, that it is not war which makes men sick, but that sick men cannot fight wars, is clearly wrong, but most of the military medical corps believe it.*

*The experiences that make real men also reveal that many are not real men at all. Real men are a minority even among heroes. Even the flying aces occasionally flew cautiously; the more sorties they had done the more cautiously they flew. They began to realise that they had more in common with the men who fell past them to crash in flames than with the brass who had ordered them to stalk and kill them.*

*Military mythology has to pretend that real men are in the majority; cowards can never be allowed to feel that they might be the normal ones and the heroes the insane. . . .*

*The principal cause of anxiety neurosis, according to the military, is fear not stress. . . .*

*The most dangerous part of any flight, especially on Malta, was landing . . . When the excitement ebbed, soul deep exhaustion took its place, and then they remembered the screams of their victims, the friends that they had lost, the stupid mistakes made and with all the reflection that they had had no time to do came guilt that they were still alive when so many were dead. . . .*

*The MO's scratched their heads. These were brave men, no mistake so why were they grey-faced and sweating, screaming in their dreams like the worst shikers and the yellow-bellies?*

*The authorities compounded their distress by accusing them of fear. They were actually too tired and dispirited to feel fear (Greer 1994).*

Thus these accounts demonstrate that there has been a striking schism between the way that some authorities, generals, doctors and pension managers conceive of and understand the experience of trauma and the genuine suffering of the victims. This demonstrates that there is an ever present tendency for those in positions of power to distance themselves from the suffering of the people and to stigmatise and blame the victim. Today these attitudes would not be presented so openly but disguised with many subtle rationalisations and administrative procedures.

## **The Conundrums for Professionals**

Medicine and the law are two professions where this division between the victim and the power elite requires constant monitoring. These prejudices and attitudes would appear to still be pervasive in the way that some 'medical experts', courts and lawyers deal with individual seeking damages. Against this background, the nature and determinants of the feelings which the victims of trauma evoke in people will be examined. In psychiatry the feelings and reactions which therapists have about patients are called countertransference. There is a recognition that these feelings and attitudes must be confronted and dealt with by therapists as they otherwise have the potential to be detrimental to the treatment process (Wilson & Lindy 1994). It would appear to be equally important for individuals in any profession or position which brings them face to face with victims to examine overtly these reactions and their origins as they can have a major impact on their behaviour.

As has already been exemplified, it is easy to see how the plight of victims can be distanced, minimised and stigmatised by those in power because their recognition can create some uncomfortable realisations. For example, how could a general who truly acknowledged the horror of war and the after-effects commit his troops to battle? The dilemma for a medical officer who treats a soldier with a combat stress reaction and then certifies him fit for battle is complex (Camp 1993). How could a military officer presiding over a court marshal commit a soldier to the firing squad for failing to charge a machine gun post in the Battle of the Somme which had 60 000 casualties on the first day, more soldiers than USA servicemen killed in the entire Vietnam war (Winter 1978)?

The essential issue is that one cannot hide behind a claim of objectivity and rationality in relation to this question about the nature of one's reactions to victims. It is critical that one confronts the reactions and prejudices that victims and their suffering evoke in each of us as individuals, if we are to be objective, as much as is possible, in dealing with the victims of trauma. This is the case whether you are a police officer, a judge, social worker, lawyer or a politician. Herman has powerfully argued that the response to victims is not a matter in

which any individual can be a passive bystander in her acclaimed book *Trauma and Recovery*. She has particularly examined this issue from the setting of dealing with the victims of sexual abuse and rape.

*To study psychological trauma is to come face to face, both with human vulnerability in the natural world and with the capacity for evil in human nature. To study psychological trauma means bearing witness to horrible events. When the traumatic events are of human design those who bear witness are caught in the conflict between the victim and the perpetrator. It is morally impossible to remain neutral in this conflict. The bystander is forced to take sides. It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear and speak no evil. The victim, on the contrary, asks the bystander to share the burden or pain. The victim demands action, engagement and remembering. After every atrocity one can expect to hear the same predictable apologies, it never happened, the victim lies, the victim exaggerates, the victim brought it on herself and in any case there is time to forget the past and move on.*

The more powerful the perpetrator, the greater is his prerogative to name and define reality and the more completely his arguments prevail. In the absence of strong political movements for human rights, the active process of bearing witness inevitably gives way to the active process of forgetting. Repression, dissociation and denial are phenomena of a social as well as individual consciousness (Herman 1992, p. 78).

### **Society's Perceptions of Victims and their Roles**

It is therefore a challenge to examine this proposition and what might influence these attitudes and the propensity for any individual to align along these polarities. Central to this question is the role that victims play in society and the dilemmas which they pose to vested interests. Firstly, some individuals who have been traumatised will become powerful agents of social change. Individuals such as Sassoon became prominent pacifists. One can speculate that Germaine Greer's understanding of her father allowed her to better capture the plight of women and the consequences of sexual domination in its uglier manifestations of rape, incest and domestic violence. Anthony Eden and Harold MacMillan, in contrast to Margaret Thatcher, were two conservative British prime ministers who were veterans of the trenches of France and presided over the establishment of the welfare state in the United Kingdom. Thus a personal knowledge of trauma may be personally detrimental but also be a powerful source of motivation for social change. Anna O, one of the original cases which Freud treated for hysteria as a consequence of her sexual abuse, became a pioneer reformer for the rights of women and the protection of children. She was described in the following terms 'A volcano lived in this woman . . . Her fight against the abuse of women and children was almost a physically felt pain for her' (Kaplan 1984, p. 107).

However, there is a social suspicion and fear that victims consume social resources and take away from the strong and the survivors. The weak are a liability to society and this was perhaps most grotesquely characterised by the first group to be exterminated by the Nazis (Meyer-Lindenberg 1991). They were

not the Jews or gypsies, but psychiatric patients. It is little wonder that in the second world war, traumatic neuroses and combat stress reactions were not recognised by the German army and many so affected were put into companies required to carry out battlefield suicide missions (Burma 1994).

Victims also challenge the values of power and demand compromise and concern. Social Darwinism, in its new disguise of economic rationalism, argues that competition and survival of the fittest should be the organising social dynamic. This is an ethos which gives little value to the energy and effort which a society puts into protecting and caring for the disadvantaged and suffering. Victims are a challenge and threat to the rights of the winner. They are attacked with the rationale that victims undermine individual responsibility. People should be responsible for what happens to them. The needs of victims are also readily conceived of as being overwhelming. Victims characterise vulnerability and are the antithesis of this competitive world.

Victims challenge the meaning structures that provide the social definitions of reality and particularly when they focus awareness on the tenuous nature of peoples' control of their lives, they are the prophets of doom and therefore readily shunned. Against this background it is easy to see that victims characterise a series of issues that cause considerable discomfort to the premise of social control and organisation and are easily stigmatised to diminish the threat which they pose.

In this context, this paper addresses a series of questions.

What are the attitudes and reactions to victims?

What are the dimensions which influence people's responses to victims?

What are the forces that have served to identify and advocate the needs of victims?

What are the issues which influence the way that victims are dealt with by the law, medicine and society?

## **Monitoring the Attitudes to Victims in the Legal System**

The administration of justice is one of the dimensions of society that most allows us to monitor the attitudes to and the experience of victims. Given the pervasiveness of social attitudes about victims and the conscious and unconscious ways they influence people's behaviour, it is reasonable to hypothesise that this ambivalence may be reflected in the administration of the law, in the decisions of judges and in the behaviour of lawyers. The paradigm of the law is that of argument and precedent. This is not a perspective that encourages the psychological and sociological analysis and scrutiny of the experience of victims who seek recourse in the courts or the practitioners who administer the system. Given the inevitability of individual bias and prejudice, there is a need to examine how these attitudes influence the administration of justice in the civil courts as well as the criminal courts. One way of investigating this question is to examine how victims experience the legal process and whether it delivers the justice it proposes or whether it becomes a vehicle for institutionalising social prejudice about victims and protecting the rights of those with political power and wealth.

This question can be addressed by examining the experience of the 1983 Ash Wednesday Bushfire in South Australia which has been researched and observed closely over the past 11 years (Marshall 1994; McFarlane 1993). These fires were a devastating event on any scale. The ferocity of the fire storm is perhaps best demonstrated by the objective documentation of flames 800 feet high. Despite the fact that liability for this disaster was determined soon after the event, claims remain outstanding in 1994, particularly those seeking damages for personal injury.

This disaster provides a setting in which it is possible to examine the ability of the legal system to understand and deal with the reasonable needs of victims. After all, one of the justifications of the rights to sue for damages in our society is that it is preserving and serving the rights and needs of the justly aggrieved and suffering. A set of principles that is critical to the monitoring and advancement of medical care will be applied to this legal process—a method which may contribute reasonably to an audit of the implementation of the law.

In contrast to the law, the process of change in medicine is driven substantially from scientific research and the resultant knowledge. Apart from the pursuit of basic scientific questions, similar methodology is used in conducting clinical trials. Medicine has also, importantly, been made to address the needs of various patient groups due to the emergence of advocacy organisations, who for example, raise many pertinent issues about the care and nurture of children in paediatric hospitals. It is illuminating to remember that thirty years ago parents' visits to children in hospital were severely restricted. Adenoidectomies were done on children without anaesthetic prior to the second world war, an issue graphically depicted in Roald Dahl's autobiography (1990). While the women's movement and victims of crime organisations have lobbied for important changes in the administration of aspects of the criminal law such as rape cases, the civil litigation system has largely been protected from the rise of consumerism. The adversarial system creates a clear schism between the defendant and plaintiffs, both of whom are consumers with shared interests.

Today, medical practice demands a series of quality assurance measures, particularly in hospital settings. These programs ensure that the outcomes of interventions are monitored and complications identified and rectified. Hospitals are also inspected and accredited by independent bodies who scrutinise the adequacy and standards of care. Increasingly health care will be funded according to output based measures which means payment will depend on the achievement of the stated goals within efficiency guidelines. Previous examples provide a basis for similar quality assurance based procedures to be applied to the law. It is interesting to speculate how the legal system would change if it were subjected to such external scrutiny which demands that goals and outcome criteria be set.

### **Disaster Victims' Perceptions of Litigation**

In a study of the victims of the 1983 bushfires (Marshall 1994), the experience of these plaintiffs of the legal process was systematically examined, applying some of these principles of audit. In particular, it aimed to examine the extent to which

the legal process met the expectations of these clients. This was an unusual setting because the plaintiffs had all experienced an event where there was no dispute about liability and where all had legitimate claims.

This study examined the experience of 32 of 92 patients who had consulted the author after the disaster and psychometric data had been collected from the disaster. The low return is a potential source of bias. However, my personal knowledge of these individuals did not suggest that their attitudes were significantly different from the nonresponders. The continuing level of distress of this population is indicated by the fact that 75 per cent still had a clinically significant post traumatic stress disorder (PTSD) 10 years after the disaster. Of the 32, 81 per cent had a personal injury claim and this was settled in only 38 per cent. This would suggest that the legal process had failed to provide a rapid settlement of these people's personal injury claims which were a result of the traumatic consequences of the disaster. This was in contrast to the property claims which had been settled for all but one of the plaintiffs by 1993. The group who had outstanding personal injury claims represented a group of plaintiffs who had a legitimate expectation that the civil damages system would deliver what it was intended to do. As a group they had sustained more property damage, had higher rates of bereavement and had higher levels of post traumatic symptomatology than those not pursuing claims. The system was not dealing with a group of litigants who had frivolous claims or who were malingering. Statutory requirements in the aftermath of the disaster meant that their losses were documented objectively soon after the event. Comparison of symptomatology in subjects with unsettled and settled claims in 1993 demonstrated that the continued symptomatology in the litigants was not simply a consequence of the ongoing litigation as the levels of symptoms were unrelated to whether the claim was outstanding.

In the light of these comparisons, how did these victims experience the legal process? It is important to stress these data are about perceptions and therefore liable to a range of biases. First, the helpfulness of the various professionals who had contact with the plaintiffs was examined. The medical experts acting for the plaintiff were reported to be helpful by 87.5 per cent of the victims, in contrast to the medical experts acting for the defence who were seen to demonstrate a low level of helpfulness by 89.5 per cent of the victims. The perceptions of the lawyers were more variable with 48.1 per cent of victims finding their lawyers showed a low level of helpfulness and only 29.6 per cent reporting them to be very helpful. Sixty-three per cent of the victims found the defence's lawyers to be unhelpful and 18 per cent helpful. The empathy of the plaintiff's medical expert was found to be high by 73.9 per cent of the victims and 79 per cent felt that low levels of empathy were demonstrated by the defence. The lawyers acting for the plaintiff were reported to have low levels of empathy by 42.3 per cent of the victims whereas 73 per cent found the defence lawyers had low levels of empathy.

Inadequate knowledge about the legal process at the commencement of litigation was an issue for 89.6 per cent of the victims. Eleven years into the process only 35.7 per cent of the victims saw that they had adequate knowledge

of the claims process with one consequence being that 94 per cent saw themselves as having minimal control over the claims process.

The processing of the claim, which demanded the repeated retelling of their traumatic memories, was felt to be highly negative by 82 per cent of the victims with 57 per cent believing that they had been traumatised by the pursuit of their claim. One contributing factor was that 93 per cent believed that there had been severe delays in the settling of their claims. The understandable reaction of 86 per cent of the claimants was anger. The adequacy of the compensation for the personal injury was anticipated to be or was inadequate in the opinion of 80.9 per cent of the victims. Property damages were thought to be more reasonable with 46 per cent seeing them as inadequate. Sixty-four per cent believed that the possible compensation settlement was insufficient to warrant the pursuit of a claim. In contrast, 64 per cent believed that a property claim was worth pursuing. When asked, 'Overall, what is your reaction to the legal system and how it is put into practice', the response of 89 per cent of the victims was negative and none were positive. Twenty-two per cent felt they had been victimised by the process or subject to prejudice.

These findings suggest that the victims of this disaster perceived the legal process to be unempathic, unlikely to adequately address their needs for compensation and the source of significant distress. It heightened the sense of victimisation from the disaster. The majority in hindsight would not have commenced proceedings which suggests that there is a need for those responsible for administering the law to seriously consider whether the legal process is more attuned to the needs of practitioners rather than the clients, a state of affairs that would not be tolerated elsewhere in society. The attitudes of the legal profession were generally perceived to be unempathic which suggests the need to examine the reality of these perceptions and how the stigmatisation of victims may be a central dynamic of the legal process. The lack of any systematic audit of the system by the courts or the government also raises questions as to why the law has not been subject to the same demands for quality assurance as other sectors of society. A system of health care which was characterised by similar negative perceptions of patient would be the subject of public inquiry and reform.

Such data do not mean that the issues of malingering and fraud do not need to be addressed. Rather, the prejudicial nature of the examination of these issues should be superseded by a careful objective examination of the issues. The fact that a lawyer can introduce a notion such as compensation neurosis, an outmoded concept with no objective validity, should be treated in the same way that the introduction of such a notion would in any serious objective examination of this question. The issue is the validity and reliability of the patient's history and the accuracy of the examination of the attendant expert. Equally, the impact of overly generous compensation schemes on disability and recovery should be the topic of serious social discourse.

These disaster victims are not alone in their reactions to the legal process. Napier, a lawyer who specialises in disaster litigation, has made the following observations about victims' experiences of the legal process:

*I have tried to understand the feelings of disaster victims and to be sensitive to what they expect from the legal system, which in my view is poorly designed to*

*cope with disaster aftermath. The victims frequently feel that in the legal process their interests come well down in the list of considerations. We have learned that as soon as the victims suffer what they see as inadequacies in the legal system, they visit their resulting dissatisfaction on who else, their lawyers. However unfair that might be, who can blame them? The result is that the medical trauma of the disaster is worsened by further trauma to the victims as they battle with a confusing system that is often slow and ineffective in providing answers that they and the public reasonably seek (Napier 1991, p. 158).*

How is it that the law has managed to insulate itself from the experiences of the citizens it claims to serve? One possible suggestion is to improve the training of lawyers about the feelings and attitudes which victims evoke. Such reactions may play a critical and unrecognised role in influencing judgments. The issue of countertransference is a critical concept in understanding the relationship between therapist and patient (Wilson & Lindy 1994). The optimal treatment of the patient demands an understanding of countertransference.

## **Reactions to Victims: Countertransference**

The behaviour of victims is a critical determinant of the responses which they evoke. A central issue is that victims tend to unconsciously relate in ways that convey unresolved and unassimilated aspects of the traumatic event. For example, victims often dichotomise the world and relationships into issues of good and evil. There is a tendency to re-enact the trauma, for example, conveying a vulnerability which may provoke further victimisation. This repetition tendency is graphically depicted by victims of child sexual abuse who may sexualise a relationship in a childlike manner. There is a fragility of the victim's sense of trust. These are feelings that can evoke issues of power and control in those dealing with victims. Also, there is a constant struggle between the need for external reassurance and the fear of re-victimisation; again, these are that can provoke complex reactions in those to whom they are directed. Thus, dealing with people who have been traumatised can be emotionally demanding and difficult. It is just as easy to fall into the role of the persecutor as that of rescuer.

Before focusing specifically on the issues that may influence the expression and origins of the feelings of legal practitioners towards victims, I will first discuss the perspectives from which the predicament of victims may be viewed. It should not be assumed that an empathic response to victims is the social norm or the automatic response to those who are suffering or traumatised.

First, there is the moral/legal perspective. One has the opportunity to choose between judging an individual's behaviour as being right or wrong or being understandable along some other dimension. For example, a person who steals food to feed a child has committed a crime that would evoke legal condemnation. The quality of an individual's behaviour during a traumatic event may also evoke moral condemnation. Somebody who survived through cowardice and at the expense of others, despite being extremely traumatised himself, is potentially subject to condemnation. Similarly, there are certain moral attitudes towards people's responses to an injury. Excessive complaint and lack of attempts to

function independently evoke condemnation and hostility. This represents one dimension upon which the behaviour of victims may be judged.

The second is a scientific or medical perspective. This involves the systematic observation of the behaviours and reactions of victims. This objective paradigm can be a powerful one in modifying society's attitude to victims as will be discussed. On the other hand, prevailing social attitudes can substantially bias observations or lead to a denial of the suffering of victims. The accounts already given of the attitude to war veterans is an example of how military doctors' explanations of combat stress reactions was very much determined by the military ethos rather than the objective facts.

The third perspective is a humanistic or philosophical one. This involves an acknowledgment of the importance of an understanding of pain and suffering and society's responsibility for dealing with these. Victims have a right to be protected from both external and internal sources of suffering. This involves a social acceptance of the idea that they are not to blame for their misfortune.

Professionals, whether they be lawyers, doctors or police officers, may instinctively use one or more of these perspectives in dealing with victims. Thus, there is a wide range of attitudes and reactions to victims. There is no one normal or natural response to victims. People's own experiences will critically determine the way that they respond to other victims. For example, somebody who has never known suffering may be more predisposed to taking a moralistic or legal view of victims, whereas somebody who has himself at one point in his life known suffering, may be more likely to take a humanistic and benevolent perspective.

Similarly, the nature of the trauma is also critical. For example, a woman may be more sensitive and receptive to the experience of a victim of rape than a man who feels uncomfortable about his sexuality. The age and number of victims will also influence responses to victims, with children perhaps evoking a greater sense of personal tragedy. Identification with the moral dilemmas characterised by an event are also critical. The strengths and resilience, as well as the symptoms of the victim, will also influence the response of the observer. Institutional and organisational factors may also be important. For example, insurance companies will characteristically have a defensive and critical view of victims. Thus, the setting in which individuals work can modify their attitudes.

It is important also to realise that countertransference reactions can fall along a dimension ranging from avoidance to over identification (Wilson & Lindy 1994). Avoidance is characterised by a variety of strategies which essentially distance or minimise the suffering of the victim. This may be done by suggesting that the victim is exaggerating the experience or the effect that it has had on them. On the other hand, an individual may over identify with a victim and wish to deal with or resolve his/her own issues and difficulties by taking on those of the person who he/she represents. For example, a victim of child abuse who works in a sexual assault referral service may be unable to objectively assess the victims of such crimes.

## **Reactions to Victims in Civil Litigation**

The ethos of the criminal justice system seems also to affect the setting of criminal litigation. The criminal justice system ensures the rights of the accused and by its adversarial nature allows the discrediting of witnesses through cross-examination. Cross-examination can use the subtle exploitation of prejudice to challenge arguments and perceptions. Thus, the courtroom can lead to the expression of attitudes which would seem to be discriminatory and prejudicial in other settings. This has recently caused considerable comment about, for example, what is acceptable force in a marital sexual relationship in a number of rape case judgments in Australia.

As well, plaintiffs often feel that they are on trial rather than the defendant. The balance of power is often tilted when the defendant is an insurance company with considerable resources to defend the case, in contrast to the limited resources of the plaintiff. For example, after the bushfires, where a public authority was deemed to be liable, the resources of the defence were substantially greater than those of the plaintiffs. Because of the cost of the litigation, the plaintiffs were faced with the possibility of losing their houses and property on a second occasion.

It also seems that the procedures of civil litigation do not take account of the nature of post traumatic reactions. For example, victims will often go to considerable lengths to avoid discussion of their traumatic memories and experiences. Litigation requires the repeated provision of statements and focusing on the traumatic event, which exacerbates their distress, and some react by simply withdrawing from the process.

Also, the area of traumatic stress has burgeoned at an enormous rate in the last fifteen years. There would be few expert witnesses in private practice who are familiar with the current knowledge base in this area or could provide a sophisticated critique of some of the current conceptual and methodological issues. Similarly, lawyers' lack of scientific training equips them poorly to test the validity of opinions based on the recent literature.

It is easy to see how a defence lawyer may develop a very different set of perceptions about victims than will a plaintiff's lawyer. Equally, medical experts appearing for the defence and plaintiff may often have quite different views about the same information. It is important that the courts should systematically scrutinise these attitudes because they may substantially interfere with the objectivity of the argument and the data presented. The determining factor in a case may well be the way the case is argued and not the scientific validity and reliability of the assertions being made. For example, a victim who is being examined by a hostile medical expert is likely to be provoked into a variety of behaviours as a consequence of his/her sense of re-victimisation in this setting. This will significantly influence the quality of some of the information that will be provided. For this reason, it is critical that the courts openly examine how the expert's behaviour may modify or influence the reaction of the victim.

## The Importance of Scientific Observation

The systematic study of the psychological effects of trauma highlights the reluctance of society to accept the prevalence of trauma and the detrimental nature of its effects. The power of individual's prejudices are highlighted in this context. This is reflected in Kardiner and Spiegel's (1947) historic monograph about the effects of combat in the second world war.

*The subject of neurotic disturbances consequent upon war has, in the past 25 years, been submitted to a good deal of capriciousness in public interest and psychiatric whims. The public does not sustain its interest, which was very great after World War I, and neither does psychiatry. Hence these conditions are not subject to continuous study . . . but only to periodic efforts which cannot be characterised as very diligent. In part, this is due to the declining status of the veteran after a war . . . Though not true in psychiatry generally, it is a deplorable fact that each investigator who undertakes to study these conditions considers it his sacred obligation to start from scratch and work at the problem as if no one had ever done anything with it before (Kardiner & Spiegel 1947).*

Against this background the acceptance of post traumatic stress disorder in 1980 as a formal psychiatric diagnosis represents an important landmark in the social acknowledgment of the consequences of trauma (APA 1980). There are few psychiatric disorders which have evoked such controversy as PTSD and this continues. The issue of the effects of trauma is again the focus of a major suspicion because of the false memory debate. In the course of therapy some patients access apparent memories of child abuse and in the USA the patients not infrequently sue the abusing parent or adult on the basis of these memories. There has been an increasing public backlash about these cases with the parents claiming that they have been wrongly accused and that these memories have been produced by the inappropriate technique of the therapist working with highly suggestible patients. Organisations such as the False Memory Syndrome Foundation have been formed to support and argue the case for parents who claim to be wrongly accused.

This debate has tended to further polarise opinions between the believers and the sceptics about traumatic phenomena, with the clinical and scientific questions being increasingly lost in the heat of the argument. This highlights the danger of clinicians becoming advocates for patients in legal settings and the need to maintain a healthy degree of doubt when working with such patients. The possibility must be considered that the patient has a history of trauma which accounts for the tendency to dissociate but that the content of the memory does not lie in an event which actually occurred. The author has treated five patients with PTSD who have independently validated histories of extreme traumas who in the course of their illness have developed flashbacks of events which have no basis in reality and this was recognised by the patient. Thus the circumstances which led to the development of these memories is of particular interest from a theoretical view. Unless a degree of caution is exercised in accepting the content of patients' memories, this debate could be the seed which again dooms PTSD and the dissociative disorders to be a passing fashionable interest, and condemns

them to the periphery of acceptable psychiatric practice (Atchison & McFarlane 1994).

This controversy demonstrates the capacity of trauma related issues to polarise opinion and why each individual who becomes involved with victims needs to be aware of his/her personal reactions as they have such an ability to bias one's judgment. PTSD is an important concept in the objective examination of the suffering of victims for a number of reasons. First, the central aetiological issue is the role of the trauma and the psychopathological process which it initiates (Spiegel 1988). The critical element of the trauma is the helplessness and the threat which people have to endure. Historically, this aspect of patients' experience has so often been denied. In this regard, in contrast to other psychiatric diagnoses, PTSD focuses on the event rather than the individual, although the role of other individual factors is important in understanding the onset of the disorder.

Whilst in the 1970s there were many controversies about the stigmatising effects of psychiatric diagnosis, for some victims such as soldiers, there is an important distinction between being ill rather than being a coward. The definition of a psychiatric disorder is also important in qualifying for compensation in contrast to simply experiencing a state of distress. Finally, the definition has led to the academic investigation of the field of traumatic stress. Thus many notions and popular prejudices are now being systematically examined and this will hopefully impact on the sophistication of the examination of these questions in the courts.

The origins of the notions about the role of trauma as a significant cause of psychological disorder provide many valuable insights into the fragility of the social perceptions of victims. The first major interest in the question occurred in Paris at the Salpêtrière where Charcot held his famous demonstration clinics about hysteria. It was his hypothesis that the critical trauma for many of his patients was sexual abuse. The paralyses and sensory defects seen in hysteria were attributed to the notion that the conscious memory of the trauma was repressed or dissociated but that the symptom was representative of the traumatic reminder. Freud (1893), who was one of the observers at Charcot's clinic, said of his work

*No credence was given to a hysteric about anything. The first thing that Charcot's work did was to restore its dignity to the topic. Little by little, people gave up the scornful smile with which the patient could at that time feel certain of being met. She was no longer necessarily a malingerer, for Charcot had thrown the whole weight of his authority on the side of the genuineness and objectivity of hysterical phenomena (Freud 1893, p. 19).*

The social nature of this exercise and the process of witnessing the plight of the victim was also recognised by William James, who also attended Charcot's lectures. He commented that:

*Amongst all the many victims of medical ignorance clad in authority the poor hysteric has hitherto fared the worst; and her gradual rehabilitation and rescue will count among the philanthropic conquests of our generation (James 1894, p. 195).*

Despite evidence to the contrary, probably one of the greatest paradoxes is that Freud went on to renounce his views on the role of child sexual abuse, and therefore trauma in the aetiology of the neuroses. The reasons for this are complex, but include ostracism by his colleagues and denial of the abuse by his patients' families. He wrote in 1897, in a letter to Wilhelm Fleiss, about 'the surprise that in all cases the father, not excluding my own, had to be accused of being perverse . . . whereas surely such widespread perversion against children was not very probable' (Masson 1985, p. 108). Instead, Freud went on to formulate the hypothesis of infantile sexuality and the Oedipal complex. Neurosis came to be seen as a result of regression of the ego to a previously fixated libidinal stage (Brown 1961). Interestingly, although the psychiatric community embraced Freud's hypotheses, he himself wrote of continuing doubts. As late as 1933, he continued to emphasise that 'the traumatic neuroses are not in their essence the same thing as the spontaneous neuroses . . . nor have we yet succeeded in bringing them into harmony with our views' (Freud 1973). These writings, stressing the difference between the traumatic neuroses and other neuroses, have been essentially ignored.

Paradoxically, with the current acceptance of the prevalence of sexual abuse (Herman 1992), Freud's earlier ideas about neurosis now have much greater credibility than his libidinal theory. There is little doubt that Freud's denial of the prevalence of sexual abuse is probably one of the most detrimental influences on the recognition of trauma this century. As a consequence, generations of patients were not believed.

Perhaps one of the best safeguards against such denial and the corresponding danger of exaggeration and malingering is to use, wherever possible, systematic research with reliable and valid measures to examine these issues. Such an approach has proved to be most illuminating in examining the effects of the Iraqi occupation on the Kuwaiti population and the legitimacy of the compensation that is to be paid as a consequence of the specific United Nations Security Council resolutions. The available data collected from a series of epidemiological studies demonstrates the prevalence of systematic torture of the civilian population and that as many as 30 per cent of the population had a PTSD two and a half years after the occupation. The author was asked to audit this process by the World Health Organization last year and as a consequence would argue that similar research after most major disasters, which are liable to become the subject of litigation, is a valuable method of systematising judgments about damages. This requires the courts to work in much closer collaboration with the experts who study these events. Such an approach after the *Herald of Free Enterprise* sinking in 1986 led to an expeditious and rapid settlement of the claims of that disaster (Napier 1991), in contrast to the 1983 bushfires.

## **The Paradoxes created by Knowledge**

This paper has focused on some of the factors that can influence attitudes to victims and the importance of society considering their predicament empathically. This would not seem to be too controversial. In victimology there is a tendency to think of the victim and the perpetrator. Thus the legal, scientific

and humanistic understanding of victims are not in conflict. However, a recent study of female prisoners, conducted with Raeside (1994), demonstrated that 81 per cent of this population currently suffered from a post traumatic stress disorder. The traumatic events experienced included rape or sexual assault by 71 per cent, childhood sexual abuse by 55 per cent and physical assault by 32 per cent.

In general, these women had been symptomatic since adolescence, with symptoms often preceding their history of criminal behaviour. Many of their crimes related to the need to support their drug abuse which in many represented an attempt to self-medicate their traumatic symptoms. It is intriguing that while there are many studies of psychiatric disorders in female prisoners, no others have examined this issue of trauma or PTSD. Thus, these data indicate that female prisoners, who have rightfully been condemned by the due legal process, can equally be understood from a medical and humanistic perspective which might suggest that incarceration does not adequately deal with their behaviour. The division between perpetrator and victim is clearly blurred in this population which indicates the complexity of the reactions such women are likely to provoke. Equally, the legal and medical perspectives about trauma may predict very different interventions.

It is interesting how many of these issues about trauma are understood in literature but not addressed in medicine or the law. For example, the dilemma of how to consider the suffering of murderers is considered at length by Shakespeare in *Macbeth*. *Macbeth*, even in the scene where Duncan is murdered, is plagued by his traumatic ruminations.

*What hands are here? Hah: they pluck out mine eyes  
Will all great Neptune's Ocean wash this blood  
Clean from my hand? No (Macbeth, Act II, Scene I, p. 929).*

Lady Macbeth dies from her traumatic madness not long after she wanders the stage in a somnambulant trance lamenting:

*Out, damned spot: out I say . . . Yet who would have thought the old man to have  
had so much blood (Macbeth, Act V, Scene I, p. 940).*

## **The Need for Reform**

The growth of knowledge about the effects of trauma raises many questions about the way victims are dealt with in our legal system. There is ample evidence that many of the attitudes that remain are prejudicial and discriminatory. While the needs of victims have been addressed to a degree in the criminal courts, little consideration has been given to these questions in the civil courts. The origins of prejudicial reactions to victims are complex and have the ability to influence professionals' behaviour in a variety of subtle and indirect ways. These attitudes within the legal system need to be directly examined and articulated.

The data presented about the 1983 Ash Wednesday disaster victims' pursuit of personal injury claims suggests that this was a traumatic process and they did

not feel that justice was delivered. If this is the case, one would assume that no lawyer would want the continuation of a system which does not adequately serve the rights of those who reasonably seek to use it. Failure to institute reform would suggest that the legal process is self-sustaining and unresponsive to the needs of those it is supposed to serve. Politicians likewise have an obligation to actively ensure the administration of justice.

To conclude, the needs and predicaments of victims are easy to stigmatise and ignore even within systems, such as civil jurisdictions, which are designed to address their needs. However, the importance of listening with a sense of empathy should not be minimised. Sassoon described such a sentiment when he spoke of the physician who treated his PTSD:

*He made me feel safe at once, and seemed to know all about me . . . I would give a lot for a few gramophone records of my talks with Rivers. All that matters is my remembrance of the great and good man who gave me his friendship and guidance* (Sassoon, in Fussel (1983), pp. 134, 136).

It would appear that the civil litigation process does not leave the majority of litigants with such positive feelings that their rights have been addressed and their suffering acknowledged.

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