Quantifying Psychological Victimization: Scientific Uncertainty, Legal Necessity

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Quantifying psychological victimization presents a formidable conundrum for psychiatry and the law. On the one hand, the task is fundamentally uncertain, due to causal complexity that includes disparity between projected image and inner reality, context dependence, volition, and conflicting interests. On the other hand, the task is necessary for just determination in such areas of law as disability assessment, victim impact, compensation, and psychological crimes such as harassment. A multiaxial protocol is proposed to meet this problematic charge. The five dimensions of this protocol are (1) gross estimate of victimization, including severity of the stressor, the degree of resulting impairment, and variably, the degree of the victim's nonresponsibility; (2) reliability; (3) other conditions; (4) conflicts of interest; and (5) evaluator bias. Intuitive estimates are used widely here instead of operationalized criteria, to enhance flexibility and widen relevance. Evaluators are asked to determine and explain the weighting that should be given to different factors and to give a self-statement of their own biases.

"Victimization" is harm done to an individual (victim) by external events, which include the willful and negligent actions of another (perpetrator). Damage assessments are always difficult, even when there are overt physical injuries. Difficulties are compounded when the harm is alleged to have occurred at the psychological level.

Psychological or "experiential" reality is the domain of subjective experience.[1–3] This domain is private, by definition. It can be estimated only through its behavioral correlates, the validity and reliability of which are always open to question. Its substrates are consciousness and volition. These stand in tension with their opposites, "unconscious" awareness and "involuntary" action. Research findings show that it is not possible to draw clear distinctions between the opposing polarities and that such lines may not even

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exist.[4] In addition, psychological realities affect and are affected by a plethora of complex biopsychosocial forces[5] and idiosyncratic intangibles.[2] For all of these reasons, psychological realities are fundamentally uncertain: it is not possible to specify them in a way that is simultaneously precise, relevant, and reliable.[2, 6]

There is increasing pressure from both science and the law to accomplish this admittedly impossible task. Psychiatric evaluations are expected to meet stringent standards of scientific rigor. This charge imposes a corollary demand to specify precisely any variable as significant as the degree of psychological victimization.

In the law, such determinations carry high stakes. Hence, legal demands are more stringent yet. Psychological damage willfully inflicted on another is relevant to crimes such as harassment,[7] stalking,[8] and terroristic threats[9] and virtually defines the tort of "intentional infliction of emotional distress."[10] Victim impact evidence is weighed increasingly to determine the severity and punishment of criminal acts such as murder, assault, and rape.[11] Victims' compensation boards must mete out limited funds to those most deserving and in need, and the degree of psychological harm is an important factor in need assessment.[12, 13] Such harm is now a cause for action under the Americans with Disabilities Act (ADA)[14] and the 1991 Civil Rights Act[15] and has been affirmed by the U.S. Supreme Court.[16] Uncertain victimization underlies ongoing controversies over child abuse and traumatic memories.[17]

A conundrum remains. On the one hand, like other psychological phenomena, victimization cannot be quantified in any kind of way in which we can fully trust its precision, relevance, and reliability. At the same time, the task must be attempted to scientifically study the effects of victimization, optimize justice in civil and criminal courts of law, and address more effectively the many victimizing processes occurring throughout society as a whole.

Illustrating the Dilemma: Clinical Anecdotes

Several case anecdotes illustrate just how complex the task of quantifying psychological victimization actually is.

Case 1: Rape Victim An attractive young woman (RV) goes jogging in a hazardous waterfront area of a major city in the early evening, alone and wearing tight jogging clothes. She is brutally assaulted and raped. Prior to the assault, she was an effective but "difficult" employee for a local business. Afterward, she became increasingly moody, unreliable, complained of insomnia and nightmares, and used increasing sick leave due to fatigue, headaches, and gastrointestinal complaints that eluded physical diagnosis. An already unstable but intensely bonded relationship was now on the rocks, and continued employment was now being made contingent on psychiatric evaluation and treatment.

Case 2: Marginal Recruit A marginally competent high school graduate was accepted into the U.S. Marine Corps after having expended maximal efforts to prove his qualification, including willfully withholding medical data that might

well have excluded him (history of prior seizures of unknown etiology, family history of mental illness). During boot camp training, oppositional behavior led to disciplinary consequences and public shaming, after which he was hospitalized for a psychotic episode and then discharged. He now suffers from chronic posttraumatic stress disorder (PTSD), episodically uses street drugs, and suffers recurrent psychotic symptoms when under stress and/or intoxicated. To what extent was MR psychologically victimized by service-connected stressors?

Case 3: Uncommon Crook A middle-aged man has a 25-year history of disturbed personal relationships, erratic work history, and antisocial behavior that includes petty thievery, assault, fraud, perjury, and substance abuse. Close scrutiny of his records revealed that he once had been a high school honors student. At age 18, shortly after going away to college, he had been assaulted and gang-raped while walking the streets of a major city along with several buddies who fled in terror, leaving him helpless to his fate. Overwhelmed by the trauma and exaggerated feelings of shame, he never voluntarily sought help.

Analysis: Practical Considerations All of these cases illustrate complexities that must be taken into account when quantifying the subjects' degree of victimization. The most salient issues follow.

To what extent was RV victimized? At first glance, Case 1 seems uncomplicated: RV had suffered from a wanton and illegal act. Using the global assessment of function scale (GAF) from DSM-IV,[18] she showed a decrement from relatively high levels of function (range, 60–80) to moderately severe impairment (range, 30–50). Thus, she was clearly a victim, and the scope of the damages is also evident in rough outline. Two complicating factors remain relevant to this case, depending on the social context: one is the victim's contributory risk-taking, and the other, the competing pressures to seek therapeutic recovery versus monetary compensation or punitive retribution. Such "victim factors" are less relevant in criminal actions, but may be pivotal elsewhere.

The prevailing social climate is ambivalent about victims' contributory responsibility. It is a factor that is often emphasized by the defense in court, creating additional stress to the victim.[19] Elsewhere, following Ryan's influential *Blaming the Victim*,[20] it has become taboo even to discuss the idea that victims might contribute to their own misfortunes.[21] Nevertheless, victim responsibility is important to crime victim compensation boards, who must allocate resources to the most deserving.[22]

Treating clinicians often encounter a second complication: the tension between a client's desire for therapeutic recovery and for compensation and/or retribution.[23, 24] To get well often means giving up the victim role; to win redress or special status, accentuate it.[25] Therapists are torn between their duties for treatment and for advocacy.

Few reasonable persons would sympathize with MR, in Case 2. He willfully

lied to incur duties that he could not meet, increasing his own apparent responsibility and relieving that of the Corps. He created the stressor that precipitated his breakdown, and subsequently, obviated possible recovery by willful self-destructive and illegal behaviors.

At the same time, the military had accepted him into service, where a stressor did cause psychological harm to a vulnerable individual. It is unlikely that he would have become so disturbed had the event not occurred. He might well be eligible for a service-connected disability.

UC, in Case 3, is the most unequivocally a tragic psychological victim. He had been an adolescent with an open future. Through no fault of his own, he suffered a capricious and catastrophic insult that well explains his tragic reluctance to seek help, and by "but-for" reasoning, can be viewed as the principle cause of his subsequent antisociality.

UC is also the least likely to gain recourse. Few victim services were available, and would have been useless for a crime only partially reported. In addition, atypicality works against his needs in an increasingly criteria-based profession. His symptom pattern does not suggest primary trauma: no PTSD, no dissociation, none of the symptoms that clinicians typically rely on as flags for a traumatic etiology. Instead, technically, the diagnosis is personality disorder, not otherwise specified (NOS). Not all clinicians would garner the data to rule out antisocial personality. Either way, UC's subsequent violations remained knowing and voluntary (as used in criminal law).

Psychological Victimology: Scientific Uncertainties

Psychological victimization is real. Its substantive foundation is the psychological trauma response. In the uncomplicated case, harm is inflicted by an external agent upon a victim who through no fault of his or her own is utterly helpless.[26] Through complex neurobiological processes, the trauma response becomes self-maintaining and stubbornly resists extinction.[27–29] Psychological traumatization is a defining feature of PTSD,[18] and it appears to play a central although disputed role in pathological dissociation.[30, 31] It contributes, for example, to borderline personality disorder,[32] and along with other biophysical determinants, may account for nearly half of the psychopathology of patients with major mental illness.[33] It is well established as a *bona fide* scientific phenomenon and has been deemed a legitimate cause of action in legal proceedings.[34, 35]

Whether the trauma response occurs and how it is expressed still depend on complex psychosocial forces that themselves remain fundamentally uncertain. Several sources of this uncertainty are particularly germane to the degree of psychological victimization.

Deception: Image Versus Reality

Foremost is the disparity between one's outward presentation and one's inner state. This is most blatant when patients actively deceive, as in cases of malingering and defensiveness.[36] Clinicians must maintain a high index of suspicion for willful deceit in the presence of such incentives as avoiding criminal sanctions

and gaining financial advantage. Opposite to malingering, along a continuum, is Jung's "persona," the partly deceptive self-image that all humans present to themselves and others.[37] In between is the fine line between malingering and symptom formation: the former slides toward the latter whenever subjective awareness and volition are lost.[38]

The role of self-deceit in symptom formation was evident to Freud[39] and remains central to psychoanalytic theory. More recent evidence from evolutionary biology corroborates this hypothesis.[40] In addition, deception of self and others contributes to human intelligence,[41] cooperative social systems such as the law,[4, 42] and even intrapsychic structure formation.[43] There will thus always be some disparity between outward image and inner state; our task is to know the latter, but this can be achieved only through the former and through ancillary evidence.

Many victims also underreport their degree of impairment to preserve personal pride or gain some desirable status. To avoid traumatic feelings, some (e.g., many rape victims and former prisoners of war) may minimize their symptoms and instead suffer quietly with little recourse. Some victims alternate between minimizing and exaggerating their symptoms, confusing themselves and others even more.

Context Dependence To quantify something implies that it is sufficiently objective to be quantifiable. This is simply not true for psychological realities, whose structures vary profoundly with how they are defined within their social context.[1, 2, 44, 45]

How something is defined partly determines whether it is a problem, and if so, to what degree and how.[46] Whether or not a mild tactile and visual stimulus is traumatizing depends on whether its source proves to be a speck of dirt or a black widow spider. The same applies to extreme stimuli, which can be exciting, merely distracting, or traumatizing. Traumatic experience thereby can be worsened or mitigated by putting it into another perspective or "reframing."[2, 46] This malleability of psychological realities is what makes psychotherapeutic relief possible.

Intentionality Further illustrating the limits of objectivity is the fact that responders retain far more choice than meets the eye. If one makes an uninvited sexual advance toward an attractive other, for example, the latter might choose to feel complimented and give thanks along with a firm no; or instead, to take offense, feel traumatized, and file a sexual harassment complaint. Many different types of responses can be predictable after the fact.[47] Finally, religious and secular conversions illustrate how profoundly personal choice can impact how one experiences reality at every level—ergo, one's whole psychodynamic.[48] Redecision plays an important and, in some cases, pivotal role in psychotherapy.[49] Assessing victims' intentionality is critical, but inordinately complex.[50,51]

Conflicts of Interest Compounding this uncertainty are conflicts of interest, with their unavoidable potential for bias. These can be defined at four levels: intrapersonal, interpersonal, mixed-level, and intrasocietal. Intrapsychic conflicts

are between competing motivations within a subject; for example, a rape victim's dilemma of whether to preserve anonymity or seek justice by going public[19] or an injured worker's conflict between strivings for recovery or compensation.[23, 24]

Victim versus perpetrator is the prototypic interpersonal conflict. Patients' interests often conflict with those of the forensic evaluators when legal or monetary consequences are at stake. They may conflict with the providers' interests when patients threaten the providers' safety or when perverse incentives punish providers for providing indicated treatment.[52]

Mixed-level conflicts of interest occur between an individual and society; for example, a victim's financial interest in maximum compensation versus society's need for cost containment. Spanning these levels is a still more subtle tension between truth and clinical efficacy;[2] many clinical interventions may work via the very same processes that can irreparably obscure knowledge of what actually happened.[17, 53, 54]

Intrasocietal conflicts include tension between competing forces within society itself; for example, society's need to protect its citizens' safety while at the same time respecting their autonomy of free choice.

The Social Climate The prevailing professional climate can also bias assessment. The attention currently given to classic PTSD, for example, selectively favors victims with this pattern at the expense of those with atypical forms of trauma response.[35] Polarization between victims' "advocates" and "skeptics" also parallels the society-wide polarization between whether to emphasize citizens' entitlements or their obligations.[55] When such conflicts reach the courts, the adversary system of Anglo-American law also fosters dichotomous either-or thinking as opposed to the balancing of opposites. These issues all influence how victimized subjects experience themselves, how they are perceived by evaluators, and how their legal issues are adjudicated.

In a professional climate that demands objectivity, it is tempting to exclude these sources of uncertainty because of their tension with this demand. Unless they are included, however, their impact will be ever more random, capricious, and therefore unjust. To quantify psychological victimization, a method is needed to embrace the many forces and counterforces that will inevitably influence the process.

Quantifying Psychological Victimization in Courts

Psychological damages are essentially what juries deem them.[56] Traditional approaches are qualitative: to establish psychiatric incapacity and causation.[57, 58] A number of PTSD rating scales have demonstrated reliability[59–61] and convergent validity;[62] but they are limited by uncertainties about what PTSD really means,[63] other conditions that follow trauma,[30–33] and the many other uncertainties already discussed. More research is needed before psychometrics can have undisputed legal value.[64] Lees-Haley proposed a "pain norms" technique that establishes how much money the average citizen would ask for to endure the psychic inju-

ry.[65] Currently, most experts call for quantification but still rely primarily on descriptive factors such as the nature of the stressor, vulnerabilities, and social supports.[66] Expert testimony is pivotal to the outcome,[12] but with the new Daubert standards[67] may become more heavily constrained.[68]

Utilizing Uncertainty: Some Underlying Principles

Utilizing the fundamental uncertainty within psychological realities, an evaluator can enhance reliability and relevance by deliberately avoiding overprecision beyond what the subject matter allows.[2, 6] Some principles may help to accomplish this task.

(1) Victimization is a complex variable that encompasses (a) severity of the stressor (also including duration, perceived danger, and helplessness); (b) degree of resulting impairment; and (c) degree of nonresponsibility or absence of contributory negligence—all of which are complex and context dependent in themselves.

(2) Some evaluator bias is unavoidable. This bias can be mitigated by asking that it be specified openly. This is done at two levels: (a) using intuitive estimates instead of tight operationalizing; and (b) asking evaluators to estimate the weighting that is best given to different contributory factors in the specific case at issue.

(3) Intuitive estimates are more reliable than operationalizing for complex multidetermined variables.[2] Operationalizing depends on tightly specifying but a few elements to the exclusion of many others.

A viable alternative strategy is for an experienced evaluator simply to estimate the separate components, condensing them into a composite rating.[69] Compensating for their unavoidable bias, intuitive estimates may improve validity and reliability. They are multidimensional, intuitively tap all levels of the evaluator's knowledge and experience, and are less likely to omit relevant factors. A scale of 0 to 4+, which has the advantage of wide familiarity in a variety of clinical settings, has been proposed for assessing the components of traumatization.[70]

(4) Different factors are variably relevant in different contexts. Any rigid formula thus guarantees injustice. Alternatively, the weighting given to various components can be determined by the evaluator, with a brief explanation of the rationale for the values chosen. The leeway thus granted to evaluator bias is less problematic than the dangers of arbitrariness and is more compatible with the nature of human problem-solving. The demand to specify one's bias also constitutes a strong covert pressure toward evaluator objectivity.

(5) Relevance is improved by adding estimates of the degree and direction of specific uncertainties, bearing in mind that these are also fundamentally uncertain. Where confounding variables occur and recur at different levels, they can be embraced within a multiaxial schema.

(6) Either-or thinking is inappropriate, and should be replaced by questions of to what degree, in what direction, and at what level. Nearly one-third of all demented patients willfully malinger, for example, and of known malingerers, nearly a third prove to have measureable

cognitive impairment.[71] Similar polarities are victimization and concurrent conditions, and awareness and nonawareness of volition in one's actions.[4] Pervasive misbeliefs that these are either one or the other lead to inaccurate data, stigmatization, and injustice. These can be mitigated by formulating relevant criteria so as always to imply an ever-present role for each pole along these continua.

The following is a proposed methodology for quantifying psychological victimization. It encompasses the practical difficulties noted in the case examples, the sources of uncertainty described, and the principles suggested for coping with these.

A Penta-Axial Protocol for Quantifying Psychological Victimization

Evaluator estimates, unless specified, are: 0 = none; 1+ = mild (some); 2+ = moderate; 3+ = severe (much); and 4+ = extreme (maximal).

Axis I: Nature and Extent of Victimization: Global Estimate Axis I is a global estimate of victimization. Three factors are taken into account and separately estimated, in addition to a composite total, all quantified from 0 to 4+ with decimals permitted. The evaluator will specify the weight to be given to each component, with a brief narrative explaining the weighting chosen. These component factors are:

A. Objective Severity of Stressor: 0 (none) to 4+ (catastrophic).

B. Degree of Psychological Impairment. Using the GAF scale (DSM-IV, Axis V),[18] one can operationalize the decrement in adaptive functioning following the event with each 1+ increment representing a decrease of 20 points. A 4+ rating will occur rarely at this level, as when a maximally functional individual (GAF 90) becomes psychiatrically incapacitated (GAF 10).

C. Degree of Victim's Nonresponsibility. One is most fully a victim only if lacking contributory responsibility for the bad event.[22] Thus, a rating of "0" connotes a maximum contributory role (e.g., willful and severe provocation of the perpetrator), while 4+ indicates none at all. In between are 1+, nonspecific provocative behavior or gross negligence; 2+, moderate nonprotective negligence, knowingly seeking dangerous situations; and 3+, relevant carelessness. The criteria for "responsibility" closely parallel those used for legal culpability, which are voluntariness and awareness of the nature and consequences of one's actions.[4, 72]

Axis II: Reliability of the Database

A. Estimated Degree and Direction of Distorting Influences (0–4+) This includes: (1) willful disinformation: (a) malingering, factitious disorder; (b) defensiveness; and (2) involuntary distortion of symptoms: (a) involuntary enhancement, (b) denial, numbing, defensive suppression.

B. Supporting Evidence (narrative description) Evidence supporting reliability may include: (1) pattern consistent with traumatization:[38] easiest for classic patterns like dissociation[30, 31] and posttraumatic stress,[18, 73] but sometimes including borderline traits[32] and other symptomatology;[33] (2) time course consistent with traumatization, which, when

symptoms are atypical, may be the most important single factor determining the reliability of the causal link;[38] (3) consistency and congruity of the subject's presentation over extended time, with "congruity" being the match between verbal and nonverbal messages; (4) corroborating evidence; and (5) validity testing.

C. Predicted Effects of the Particular Forensic Context This is the degree to which the nature of the legal proceedings at hand might influence the reliability of the estimated victimization. Any intuitive estimate should be accompanied by a narrative explanation.

Axis III: Other Conditions

A. Other Conditions (itemize, as by DSM-IV) These conditions may be either (1) preexisting or (2) concurrent. Whenever appropriate, intuitive estimates should be offered along with narrative explanation.

B. Degree and Direction of their Effect These may be either (1) predispositive conditions, causing greater vulnerability to posttraumatic effects; or (2) additive conditions that compound the damage.

C. Effect of Personality Style (narrative description)

D. Effect of Prior Traumata (narrative description)

Axis IV: Relevant Conflicts of Interest (specify, estimate 0–4+)

A. Intrapersonal

B. Interpersonal

C. Mixed-Level

D. Intrasocietal Relevant conflicts of interest will be separately itemized in each category, whenever possible, estimating the degree and direction of their effects. This will inevitably be influenced by the evaluator's bias and contributes also to Axis II, factor C: estimated effect of the forensic context on the assessment's reliability.

Axis V: Statement of Evaluator Bias (narrative description) This axis briefly summarizes the evaluator's own assessment of the degree and direction of the effects that his or her world view and value priorities might have on the assessment process. Like Axis IV, it is intended to introduce this important factor into evidence that can be cross-examined, and indirectly, foster more objectivity. The content will appear in forensic reports more specifically in the narrative justification for the weightings given to the three factors of Axis I.

Discussion: The Limits of Victimology

Three case anecdotes were presented earlier, along with a brief discussion of the issues that they raise. Space does not permit a detailed application of the entire protocol to these cases, but they can provide a departure point for preliminary interrater reliability testing. In Case 1 (RV), the evaluation is relatively straightforward, with contributory responsibility minimally complicating Axis I, gross estimate, and some intrapsychic conflicts of interest between therapeutic recovery and social gain. In Case 2, MR's willful deceits raise the question of whether he should be considered a victim at all; reliability is impaired by voluntary and involuntary symptom exaggeration, and concurrent conditions are both predispositive and additive. Mixed-level conflicts of interest occur between MR's

need for support and society's need to allocate scarce resources to the most deserving. In Case 3, UC's victimization approached 4+, but poor reliability worked against him, paradoxically, at two levels: defensiveness and atypicality. Intrasocietal conflicts of interest feature the tension between needing to compensate for its failure to protect and not wanting to encourage antisocial behavior even from otherwise deserving recipients.

A fourth case anecdote is offered to illustrate the extremes of the ambiguity, complexity, and uncertainty already described—along with the scope of their importance to psychiatry and the law, individuals, and society. In the spirit of evaluator self-assessment, I will conclude with my own biases in regard to this case vignette.

Case 4: Treatment Casualty TC is a middle-aged nurse who consulted a licensed psychotherapist for episodic distress, marital tension, and a variety of self-defeating behaviors. Sleep was fitful, punctuated by nightmares with violent and occasionally sexual content. Her family was intact but emotionally distant: her father was a white collar worker and her mother a housewife with undiagnosed medical complaints.

Other than her parents' "not being there" emotionally, TC denied physical or sexual abuse. She became visibly anxious whenever her therapist pursued these topics, which convinced the therapist that severe abuse had indeed occurred and that the patient was in denial. TC began to question everything: her family, her memory, and her ability to function. After two crises, the therapist became convinced that memory recovery work was mandatory. The patient was asked to read a suggestive self-help manual. Guided imagery work elicited fleeting traumatic images, and before long, well-organized memories of forced incest by her parents emerged.

After her initial refusal was overcome by the therapist's persuasion, TC confronted her parents. Aghast, they angrily refused to cooperate with anybody who could make such outlandish allegations. TC then sued her parents for child abuse, withdrawing the action only after it had been highly publicized.

TC is still in therapy, has made several suicide attempts, and is now divorced, unemployed, and minimally able to function. Her father was fired from a high profile job just months before qualifying for full retirement. After many of their long-time friends pulled away, TC's parents moved to another state.

This case illustrates to an extreme the difficulties inherent in trying to quantify psychological victimization. Before even starting, one must answer the following questions. Did victimization occur? If so, to whom, by whom, and how? Were TC's parents willful perpetrators, normal but inadequate parents, or victims themselves of therapeutic wrongdoing? If the latter, was TC also a true victim of an overzealous therapist, his cult-like indoctrination techniques, a large scale social movement that fosters these, or a society that is only slowly trying to confront such movements? Was the therapist malicious, or simply naive; a victim himself of good intentions and a societal craze? Or did he fail to diagnose a major depression that

might have resolved quickly with supportive counseling and antidepressant medications?

It would be easy simply to exclude such cases from our analysis as too complex or too politically sensitive. This would not suffice. Cases like this occur frequently and carry high stakes for those involved as well as for society. It remains necessary to attempt the impossible: to estimate the degree of psychological victimization. And this case strikingly illustrates the fact that one's social milieu and society itself must be an integral factor in these assessments.

TC's parents might have abused her, but there is no tangible evidence; hence, they must be presumed innocent. If early abuse could be identified by independent data, one can still argue that the patient was victimized by the therapy process itself. Rather than promoting healing and competency,[74, 75] treatment was unnecessarily traumatizing and regressive. Further analysis proceeds from this premise.

Within this context, I estimate the stressor's severity at 3+, the resulting impairment as 3+, and the degree of nonresponsibility as 2.5+. The patient was responsible for her choice of therapist and for not standing firm against suggestive persuasion, seeking a second opinion, or giving her parents the benefit of doubt in such a serious matter. These factors were mitigated by her demoralization and her reasonable expectation that a licensed therapist be competent and objective.

Witnesses are presumed to have given consistent accounts in this case. Hence, Axis II is not contributory to the overall assessment.

Axis III encompasses a pivotal preexisting condition: dysthymic disorder, approaching DSM-IV criteria for major depressive disorder.[18] This was predispositive as well as additive, making her vulnerable to therapeutic traumatization and mitigating her own responsibility. That it should have been diagnosed and might easily have been treated emphasizes the harm that also can be done indirectly by such a one-sided approach.

Conflicts of interest (Axis IV) were pivotal at all levels: at the intrapsychic level, among TC's protective intuition, original values, parental attachment, and need to trust her therapist; at the interpersonal level, between the therapist and the victim's parents and between the therapist and the patient, as manifest in TC's initial protests. This tragic case was also one of many in a battleground for one of the most desperate intrasocietal conflicts in which psychiatry is involved: victims rights[20] versus personal responsibility for all parties.[21, 55]

My own bias, Axis V, is that all parties are victimized by polarized debates in which each side treats the other as an enemy and actively suppresses discordant data from the other's research. No individual or group can win. The unequivocal victor is the power of traumatic reenactment,[26, 27] now being enacted throughout society.

Within a less traumatized and retraumatizing milieu, more therapists would remain objective and more patients would stand firm in the face of those who do not. More victims, I believe, will benefit by eschewing the victim role, learning from their tragedies, and using their wisdom

plus new skills to move ahead. Only then will more patients and society begin to heal.

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