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Negative Social Reactions to Victims: An Overview of Responses and Their Determinants

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A breast cancer patient finds that her daughter is not as accepting of her as she was prior to her cancer diagnosis. She feels like a stranger around her daughter.

An AIDS patient is told by his sister that he isn't welcome to stay in her house, or even to eat there anymore.

A childless woman dealing with infertility is advised by her husband's relatives that she should divorce him so he can have children with someone else.

Three brothers test positive for HIV. After word spreads of their infection, their barber refuses to cut their hair, and their minister suggests that they stay away from Sunday church services. Eventually, the family's house is burned down.

These quotes do not represent hypothetical examples. They are real instances taken from newspaper articles, and interviews with victims of negative life events. The behavioral and emotional responses these quotes illustrate can be defined as negative social reactions to people who are suffering or distressed. Unfortunately, they are responses that occur reasonably frequently when someone experiences a negative life event. What prompts negative social reactions from network members? This chapter addresses this question.

Although the overriding tendency of people is to try to help or support others who are suffering, responses to victims are often also hurtful. The "victimization perspective" suggests that when negative life events occur, network members may have difficulty providing effective social support, and may therefore react in unhelpful and negative ways (e.g., Coates, Wortman, & Abbey, 1979; Dunkel-Schetter & Bennett, 1990; Dunkel-Schetter & Wortman, 1981, 1982; Silver, Wortman, & Crofton, 1990; Solomon, 1986; Wortman & Dunkel-Schetter, 1979;

Wortman & Lehman, 1985). The victimization perspective was first developed in social psychological research on innocent suffering (Lerner, 1971; Shaver, 1970; Walster, 1966; Wortman, 1976), and in research on cancer patients (Dunkel-Schetter & Wortman, 1982; Wortman & Dunkel-Schetter, 1979). Since then, it has become clear that other victimized populations also experience negative social reactions from network members, mixed together with supportive responses (e.g., Blasband, 1989; Cohen & Lichtenstein, 1990; Lehman, Ellard, & Wortman, 1986; Manne & Zautra, 1989). Wortman and colleagues have offered some reasons why negative or unhelpful responses might occur, including a social network member's feelings of vulnerability (Dunkel-Schetter & Wortman, 1981; Wortman & Dunkel-Schetter, 1979), uncertainty about how best to help (Wortman & Lehman, 1985), and misconceptions about how victims "typically" react to negative life events (Silver & Wortman, 1980). However, a complex set of circumstances operate for victims and their network members in the context of a negative event. In order to more clearly understand the social ramifications of life events, there is a need for greater precision in specifying both the social reactions of network members and the factors that are important determinants of them.

To this end, this chapter details several negative reactions that victims encounter, and describes the way victims also experience inconsistencies in social reactions. Then, based on the available empirical research and theoretical work, the determinants of these negative social reactions to victims are discussed. Literature from several different research traditions has been integrated, including psychological research on "victims" (e.g., rape victims, cancer patients, bereaved persons), the interdisciplinary social support literature, and the social-psychological helping literature. In addition, because victims of negative life events are often distressed or depressed as a result of their victimization, the research on social reactions to depressed people has been included where appropriate.

The use of the term "victim" may seem derogatory but this is not intended. It is used for convenience and for lack of a better term, and is meant to distinguish individuals for whom major negative life events occur from their social network members. Further, the term connotes some element of uncontrollability in the event, and that the event causes suffering or distress for the victim.

A TYPOLOGY OF SOCIAL REACTIONS TO VICTIMS

Many studies find that victims experience both positive and negative social reactions, often from the same network member (e.g., Blasband, 1989; Cohen & Lichtenstein, 1990; Dakof & Taylor, 1990; Dunkel-Schetter, 1984; Lehman et al., 1986; Manne & Zautra, 1989; Meyerowitz, Yarkin-Levin, & Harvey, 1990; Tempelaar et al., in press). In addition, studies find that the negative or stressful social interactions that occur with network members are important predictors of

adjustment. For example, Rook (1984) found that in a sample of elderly widows well-being was more strongly related to these women's perceptions that their privacy was invaded, that they were taken advantage of, that promises of help were broken, and that others consistently provoked conflict or anger, than to the amount of companionship or emotional support they received. Other studies, operationalizing negative social interactions in a variety of ways, have reported similar effects: (Abbey, Abrams, & Caplan, 1985; Fiore, Becker, & Coppel, 1983; Pagel, Erdly & Becker, 1987; Sandler & Barrera, 1984).

It is important then, to elucidate the negative reactions, as well as the positive ones, experienced by victims. Figure 25.1 depicts the categories of social reactions we have identified from the literature. Reactions frequently mentioned in the literature have been included, but the list may not be exhaustive. It should be noted that the likelihood of experiencing each of these reactions will probably vary with a number of factors, including the nature of the relationship between the victim and social network member (Dakof & Taylor, 1990; Dunkel-Schetter & Skokan, 1990).

In Figure 25.1, negative social reactions are distinguished from support attempts. Support attempts can be further distinguished in terms of those that are effective in leading the recipient to feel helped from those that are perceived as ineffective or unhelpful. Most studies investigating the frequency and type of effective support attempts find that victims report an overwhelming amount of helpful social support, with the most helpful kind being emotional support (e.g., Blasband, 1989; Dakof & Taylor, 1990; Dunkel-Schetter, 1984; Dunkel-Schetter, Blasband, Feinstein, & Herbert, in press; Lehman et al., 1986; Lichman & Taylor, 1986). These studies, however, also find that many victims experience ineffective support attempts, including overprotection, overinvolvement (Coyne, Wortman, & Lehman, 1988), blocking open communication (Silver & Wortman, 1980; Wortman & Silver, 1987), and advice that conveys a negative attribution of the victim, including attributions of incompetence, blame, or failure (Dunkel-Schetter et al., in press). An example of the latter type of ineffective support attempt was provided by an AIDS patient whose friend attempted to cheer him up at a time when he was suicidal, by saying "Well, you just don't have a fighting spirit" (Blasband, 1989; for an in-depth discussion of ineffective support attempts, see Dunkel-Schetter et al., in press).

The distinction between negative reactions to victims and ineffective support attempts is a critical one. Ineffective support attempts might be viewed as behaviors that are altruistically motivated, but are not perceived by the recipient as helpful. Brickman et al. (1982) call this "secondary victimization," in the sense that victims are victimized a second time by awkward or ineffective efforts to help them. In contrast, egoistic (or self-serving) motivations probably underlie most negative reactions (Batson, O'Quin, Fultz, Vanderplas, & Isen, 1983). In the case of many negative responses, however, the underlying intent is not obvious and, therefore, must be imputed by the victim. For example, when network members block communication or the discussion of feelings around the event, it may be because

they believe it is in the victim's best interests (i.e., altruistic motivation; Silver & Wortman, 1980; Wortman & Silver, 1987), or because the focus of discussion is too personally distressing (i.e., egoistic motivation; Gottlieb, in press). Social network member behaviors that could be perceived by victims as either negative reactions or ineffective support attempts (depending upon the intent the victim imputes) have been categorized in Figure 25.1 in terms of the way they are most frequently viewed in the literature. For example, blocked communication is usually considered an ineffective support attempt.

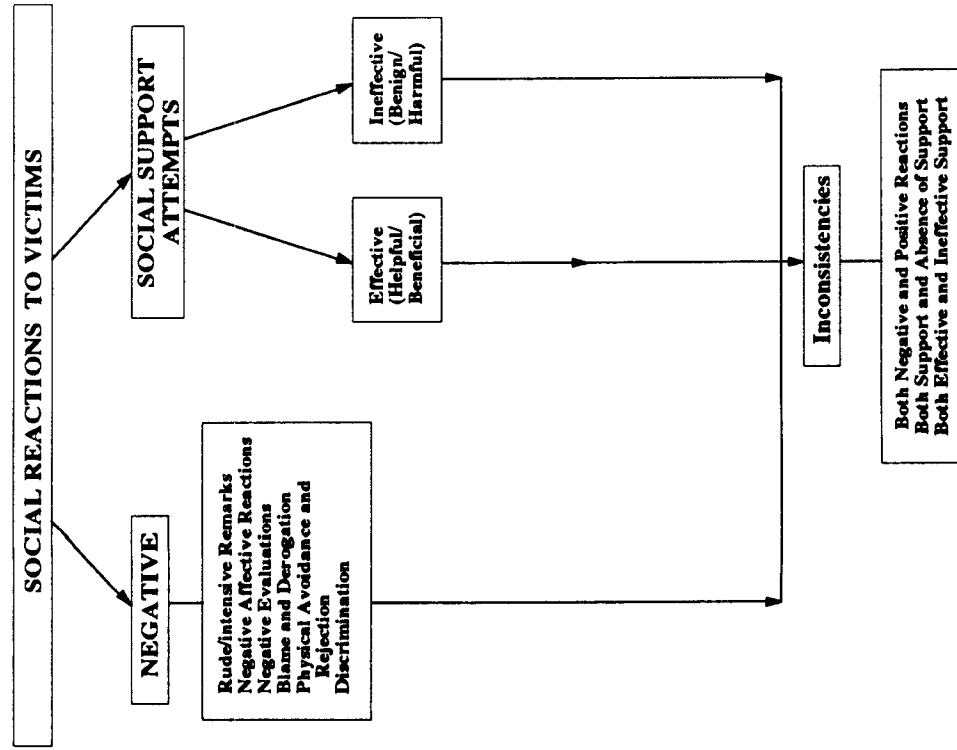


FIG. 25.1. A taxonomy of the possible negative and positive reactions of social network members to victims of negative life events.

Negative Social Reactions

Two types of research have been conducted to investigate negative social reactions to victims: (a) simulation and laboratory studies (e.g., Coates et al., 1979; Coyne, 1976a; Dunkel-Schetter, Silver, & Wortman, 1988; Lerner, 1971; Silver et al., 1990; Weiner, Perry, & Magnusson, 1988), and (b) studies that conduct in-depth interviews to gather information about the negative interactions victims report (e.g., Blasband, 1989; Dakof & Taylor, 1990; Dunkel-Schetter, 1984; Gottlieb, 1978; Lehman et al., 1986; Meyerowitz et al., 1990). Figure 25.1 depicts the six categories of negative social reactions that were extracted from these two paradigms:

1. Rude or insensitive remarks.
2. Negative affective reactions.
3. Negative evaluations.
4. Victim blame and derogation.
5. Physical avoidance and rejection.
6. Discrimination.

Rude, insensitive, and inappropriate remarks of others are one common type of negative social reaction. For example, the cancer patients interviewed by Dunkel-Schetter (1984) reported being upset by being asked about "what their chances were," or whether the cancer was "all out." Rude or insensitive remarks are also common among the bereaved (Lehman et al., 1986) and AIDS patients (Blasband, 1989). For example, one AIDS patient told of a friend asking "What are you going to do when you die? What's gonna happen with your stuff?" Another AIDS patient reported, "One friend said—'What are you doing out? You're tainted'—He was joking but it hurt."

A second common negative social response involves the negative affective reactions of others, which might occur either in response to the victim or in response to the victim's circumstances. For example, an AIDS patient reported that "A friend seemed angry, almost as if I betrayed her" (Blasband, 1989), while a cancer patient interviewed by Dunkel-Schetter (1984) said that "my sister-in-law cried and cried, as if I were dead already." In laboratory studies, negative affective reactions have been operationalized as the mood of subjects following interactions with depressed versus nondepressed partners. Subjects are often found to be significantly more depressed, anxious, and hostile following an interaction with a depressed partner than with a nondepressed partner (Gurtman, 1986).

Third, following interactions with victims, others also often evaluate them negatively. This is illustrated most clearly by laboratory studies where subjects' perceptions of victims are assessed on typical person perception measures following an interaction (e.g., Coates et al., 1979; Coyne, 1976a; Dunkel-Schetter et al., 1988; Silver et al., 1990; Strack & Coyne, 1983). For example, Strack and Coyne (1983) found that following an interaction with depressed persons, subjects rated them more negatively on a variety of dimensions. They were seen as more

unpleasant, bad, uncomfortable, weak, cold, unattractive, passive, and unfriendly than nondepressed interaction partners.

Fourth, victims often report blaming or derogating remarks from network members. A typical remark is one that implicitly blames the victim for the occurrence of the event, and is illustrated by a person whose children were tragically killed saying, "[someone called] my wife an unfit mother for letting them [the children] go away with their aunt" (Lehman et al., 1986, p. 446). Two responses from AIDS patients to questions about unhelpful interactions (Blasband, 1989) also illustrate this phenomenon: "Family saying it was my just reward. Mom said it's my behavior that caused it," and "When I told my sister about having AIDS, I got a lecture about drugs, what I'm doing to myself, that I didn't have anyone to blame but myself. On one recent visit, she didn't want to see me."

This last example also illustrates a fifth set of negative behaviors—the physical avoidance and rejection by social network members that victims report experiencing. This type of negative reaction is not uncommon. For example, in the 40 AIDS patients he interviewed, Blasband (1989) found that 25% of the men reported physical avoidance by friends and family. Further, in the sample of cancer patients that Meyerowitz et al. (1990, Study 2) interviewed, 27% reported physical avoidance by family or friends following their diagnosis, while 43% reported that their family or friends withdrew emotionally. In one extreme case, a patient's spouse left him when she learned of the diagnosis. In another sample of female cancer patients, 17% reported that their daughters became emotionally withdrawn, hostile, or rejecting following their diagnosis (Lichtman et al., 1985). In laboratory studies, physical avoidance and rejection of victims has also been found, but has been operationalized in terms of a lack of willingness to interact with the victim in the future (e.g., Coyne, 1976a; Dunkel-Schetter et al., 1988; Sacco & Dunn, 1990; Silver et al., 1990).

Finally, an extreme negative social reaction that victims report is outright discrimination. Two examples from AIDS patients (Blasband, 1989) illustrate this phenomenon: "I lost my job ... He [boss] said, 'I can't have you around here. You'd be a detriment if customers found out you have AIDS,'" and "Our landlord kicked us out. 'You're sick. I want you out of my house.' He gave us an eviction notice and screwed us out of \$500."

Inconsistencies in Social Reactions

In addition to negative reactions, three kinds of inconsistencies in network member behaviors have been noted in the past (e.g., Coates & Wortman, 1980; Coyne, 1976b; Dunkel-Schetter & Wortman, 1981, 1982; Heller, 1979; Sacco & Dunn, 1990; Shinn, Lehman, & Wong, 1984; Shumaker & Brownell, 1984; Strack & Coyne, 1983; Suls, 1982). Because victims typically interact with network members on multiple occasions, it provides the opportunity for them to react in a variety

of different ways. Over time, as stress persists, the likelihood of network member behavioral and emotional inconsistencies increases (Dunkel-Schetter & Bennett, 1990; Dunkel-Schetter & Wortman, 1982). These inconsistencies in network member reactions may be especially difficult for victims to deal with because they leave them uncertain and confused about what to expect from others, and about how they might best elicit the supportive responses they desire. Inconsistencies might be especially likely to come from family members or intimates, since these are the people who have the most sustained contact with victims.

The three types of inconsistent network member reactions are outlined in Figure 25.1: (a) mixed positive and negative reactions; (b) alternating support and an absence of support; and (c) a combination of effective and ineffective support attempts. For example, a cancer patient whose daughter said "Does your arm hurt, mother? Well, don't tell me if it does" (Dunkel-Schetter & Wortman, 1982) illustrates a person being supportive to a victim one moment and rejecting the next. Discrepancies may also occur between behaviors in different situations and at different times (Dunkel-Schetter & Wortman, 1982), as, for example, a friend who provides a great deal of attention to a victim immediately following an event, but subsequently does not visit or call at all. There may also be discrepancies between a person's expressed intentions and their subsequent behaviors (Dunkel-Schetter & Wortman, 1982). For example, people may promise to call or visit but then fail to fulfill these promises. Finally, an example of the combination of providing emotional support but blocking open communication is provided by the husband of a breast cancer patient who said "I've always kind of played [the cancer] down, rather than to get into any involved conversations over it. I let her know that I consider that it could be serious, but that I'm sure she'll come out of it all right" (Lichtman, 1982).

Summary

The overview of negative social responses presented above is the product of an integration of two relatively extensive and disparate literatures: simulation and laboratory studies, and studies that conduct in-depth interviews to gather information about the negative interactions victims report. Six types of negative social reactions were distinguished and illustrated, including rude or insensitive remarks, negative affective reactions, negative evaluations, victim blame and derogation, physical avoidance and rejection, and discrimination. In the remainder of this chapter, possible determinants of these negative social reactions are discussed.

DETERMINANTS OF NEGATIVE SOCIAL REACTIONS TO VICTIMS

A variety of factors might determine whether social network members respond negatively to victims. The factors investigated thus far include characteristics of the victim, characteristics of the social network member, and the mere presence or occurrence of a victim status.

Victim Factors

Two factors specific to victims have been shown to lead to different sorts of social reactions. Specifically, displays of victim distress and victim coping attempts have been separately related to the occurrence of negative social reactions.

Victim Distress

There is considerable evidence that negative social reactions are elicited by a person displaying depressed affect. This line of research began with Coyne (1976a, 1976b), who randomly assigned students to have a brief telephone conversation with either a depressed or nondepressed partner. In these brief encounters, reactions to clinically depressed persons were more negative in a variety of ways, including derogation, negative evaluations, and affective reactions.

Since this early research, many studies have been conducted which suggest that depressed persons are likely to be rejected by others (e.g., Boswell & Murray, 1981; Hammen & Peters, 1978; Robbins, Strack, & Coyne, 1979; Sacco & Dunn, 1990; Strack & Coyne, 1983; Winer, Bonner, Blaney, & Murray, 1981). Measures of rejection have included unfavorable perceptions, unwillingness to interact in the future, and blame. Gurtman (1986), in a review summarizing the findings of these studies, concluded that the rejection of depressed persons is consistent across the different types of dependent measures (e.g., questionnaire or behavioral), subtle variations in target characteristics (e.g., clinical in- or out-patient, student, confederate, hypothetical), and method of exposure to the depressed person (e.g., taped interview, telephone conversation, face-to-face interaction, transcript or recorded description).

Other studies suggest, however, that negative responses are not only elicited by depression. Simply expressing negative affect as a result of one's life circumstances also elicits negative social reactions. For example, one study (Coates et al., 1979) found that rape victims who expressed negative affect over a rape that had occurred six months previously were rated as significantly less attractive and experienced more derogation and rejection than victims who expressed positive affect. Another study (Winer et al., 1981) also found that individuals expressing negative affect like sad mood, pessimism, and feelings of helplessness following two different negative life events (rejection from law school or a relationship break-

up), were rated as less attractive and experienced more rejection than those who did not express these negative feelings.

Dunkel-Schetter et al. (1988) conducted a telephone interaction study modeled closely after Coyne's (1976a) study. In this study, depressed or nondepressed college students spoke with other nondepressed college students over the telephone. The results of the study indicated that perceiving any deviant or depressive behavior in one's interaction partner was associated with consistently more negative reactions. Specifically, perceiving that one's interaction partner was experiencing difficulties, dwelling on the negative aspects of his or her situation, or was exhibiting a high self-focus, led to less willingness to interact in the future, less favorable impressions, more negative feelings during the call, and more anger and depression afterwards. These findings were intriguing in that it was not specifically the "depressed" interaction partners who elicited these negative reactions, but *any* caller who appeared distressed. Thus, nondepressed college students who exhibited any deviant affective behavior experienced negative social reactions as a result.

Finally, a recent study (Silver et al., 1990) manipulated how well actual female cancer patients appeared to have adjusted to their illness and investigated the responses of others interacting with them. The patients either communicated the information about the distress they currently experienced over their cancer, that they experienced little distress, that they experienced a great deal of distress, or that there were times when they felt distressed and other times when they did not. Silver et al. (1990) labeled these conditions "no-information about coping," "good coping," "poor coping," and "balanced coping," respectively. In addition, a healthy comparison condition was included. Responses of the interaction partners were assessed in a variety of ways, including behavioral, nonverbal, and written assessments. Results suggested that relative to the targets who presented themselves as "good" or "balanced copers," subjects reported significantly less attraction toward the "poor copers," sat further away from her during the interaction, reported more distress following the interaction, and expressed less willingness to interact with her in the future. In addition, more nonverbal signs of discomfort were seen in subjects who interacted with cancer patients who communicated a great deal of distress. Thus, the rejection of victims showing difficulty in adjustment was multifaceted and included behavioral avoidance, nonverbal signals of discomfort, and negative evaluations.

A provocative implication of the results of Silver et al. (1990) is that even victims who communicate no distress about their circumstances may be targets of negative social reactions. In particular, cancer patients who communicated little distress elicited more nonverbal signs of discomfort during the interaction than did those who portrayed a more balanced picture, and subjects expressed significantly less interest in future contact with these "good copers." It appears then that victims who display either too little or too much distress as a result of their circumstances are likely to elicit negative reactions from others. Silver et al. (1990) suggest that those

who interact with victims displaying too little distress may believe that the victim is simply concealing their distress. Thus, subjects' lack of interest in future contact might be a result of wanting to avoid the distress that they expect would be revealed in future encounters.

Victim Coping Behavior

Evidence has accumulated for the link between the specific coping behaviors of victims and the subsequent negative social responses they experience. Schwarzer and Weiner (in press) recently completed a study that manipulated the apparent coping behavior of victims, and assessed subjects' reactions to them. Specifically, Schwarzer and Weiner used a within-subjects Latin Square design, where each subject received four versions of scenarios depicting an individual who had experienced one of eight stigmatizing events: cancer, AIDS, drug abuse, coronary heart disease, anorexia, depression, obesity, or child abuse. Coping behavior was manipulated by describing the victim as either engaging in situation-specific problem solving behaviors or failing to do so. Responsibility for the onset of the event was also manipulated, by describing the victim as having had control over the cause of the problem, or as having been an innocent victim. Results suggested that both more onset responsibility and less active coping efforts on the part of the victim were related to negative social reactions, but that coping behavior was more strongly related. Specifically, victims portrayed as actively coping with the event were blamed less, were attributed a better chance of improvement, and were less stressful for others socially.

One specific coping behavior that victims might employ to decrease their experience of negative social reactions is to alter their social interactions to avoid the negative reactions. They might do this by withdrawing from social interaction, by not revealing their victim status, or by avoiding mentioning their circumstances around those who are already aware of them. There is some suggestive empirical evidence that supports this, although we could find no direct empirical support. For example, Brewin, MacCarthy, and Furnham (1989) investigated whether victims' perceptions and use of the social support available to them when negative outcomes occur were influenced by their appraisal of those outcomes. They found that victims who thought the event was more likely to happen to them than to others, who blamed their own inadequacies, and who attributed the outcome to global factors, were more likely to have withdrawn socially. Brewin et al. (1989) speculated that the reason for victims' social withdrawal was to avoid the negative social reactions they expected, due to the belief that their victim status would be stigmatized by others.

Descriptive studies also support the notion that victims construct their social experiences so as to avoid negative social reactions. For example, Gottlieb (in press) has noted that many of the parents of children with cystic fibrosis and juvenile diabetes whom he interviewed reported monitoring the level of distress they displayed to their spouse in order to avoid marital conflict over their child's illness.

Meyerowitz et al. (1990, Study 2) also found that while only 13% of the cancer patients they interviewed reported no changes in their close relationships following the diagnosis of their cancer, all of these subjects had attempted to conceal their diagnosis whenever possible, and had avoided any reference to "cancer." AIDS patients also protect themselves from rejecting social experiences; but they seem to do this by avoiding contact with those whom they believe will respond negatively to their circumstances (Blasband, Dunkel-Schetter, & Herbert, 1990). Finally, victims may attempt to avoid negative social responses when they believe that the cause of the event will be perceived as arising from involvement in an activity that network members did not approve of in the first place (Gottlieb, in press; Pearlman & McCall, in press). Thus, depending on the nature of the event itself, victims may anticipate more or less criticism, hostility, and rejection from social network members, which may affect the likelihood of their engaging in interactions that acknowledge or center around their victim status.

Social Network Member Factors

In this section, characteristics of social network members that might determine whether they respond to victims in a negative fashion are discussed. The factors addressed include network members' needs to reduce feelings of vulnerability regarding the possibility that victimizing events will happen to them, attributions made by network members regarding the cause of the event, the specific affect induced in network members as a result of the victim's plight, and network members' feelings of helplessness and frustration.

Social Network Member Needs/Beliefs and Vulnerability

Early research and theory in social psychology considered reactions to victimization and suffering, and found that, generally, innocent victims are subjected to derogation and blame by others (Lerner, 1971; Walster, 1966; Wortman, 1976). Three lines of reasoning were put forth to account for these seemingly undeserved negative social reactions. First, Walster (1966) suggested that persons' assignment of blame for a negative event will be affected by their desire to avoid the frightening thought of their own victimization. Further, she proposed that derogation and blame of innocent victims would be more likely with increasing severity of the consequences of the event, and when the outcome of the event is personally threatening. There is some empirical evidence to support this assertion (Chaiken & Darley, 1973). The exception seems to be the case where a person feels highly similar to a victim, and realizes the strong possibility that the negative event could happen to them. In these cases, "defensive attributions" seem to be more likely (Shaver, 1970). That is, people appear motivated to avoid blaming and derogating victims because they would not want to be blamed or derogated if the event should happen to them.

Lerner and colleagues have offered a second account for the undeserved derogation and blaming of innocent victims (Lerner, 1971; Lerner, Miller, & Holmes, 1976). Lerner argues that people have a need to believe in a "just world" in which people "get what they deserve and deserve what they get." If we can believe that people do not suffer unless something is wrong with them or their behavior, we will feel protected from undeserved suffering ourselves, and our feelings of vulnerability to similar fates should be reduced. There is empirical evidence that supports the notion that the need to believe in a just world is related to the derogation and blaming of innocent victims (Lerner, 1971; Lerner & Mathews, 1967; Lerner & Simmons, 1966). In addition, recent evidence (Montada, Mathews, 1967; Lerner & Schneider, 1990) also suggests that blaming victims may be functional for preserving the belief in a just world because if victims are held responsible for their plight, the issue of justice is simply not raised.

Finally, in an attempt to integrate both Walster's (1966) and Lerner's (1971) formulations, Wortman (1976) has suggested that our needs for predictability and control are important mediators of our tendency to respond in a negative fashion to victims. Specifically, if we are able to derogate and blame innocent victims, we will feel more able to control the future occurrence of negative events in our own lives, and hence, our own suffering and distress. Moreover, if we can blame and derogate victims for the occurrence of negative events, our own assumptions about the world as a predictable and orderly place will not be threatened (Wortman, 1976).

Social Network Member Attributions About Event

Weiner and colleagues have employed an attributional framework to investigate the effects of others' attributions about the ability of victims to control the onset of the event or condition, on subsequent negative and positive reactions (see Weiner, 1985, for a review). Negative reactions in this research paradigm have been operationally defined as unwillingness to help victims, whereas positive reactions have been operationalized as willingness to give help, charity, or social support. This program of research has repeatedly replicated one particular pattern of findings. Specifically, results suggest that stigmas perceived as onset-uncontrollable elicit pity and greater willingness to help, while those perceived as onset-controllable elicit anger and less willingness to help (e.g., Betancourt, 1983; Reisenzein, 1986; Schmidt & Weiner, 1988; Weiner, 1980a, 1980b; Weiner et al., 1988). In addition, in the Schwarzer and Weiner (in press) study described earlier, individuals seen as responsible for the onset of stigmatizing conditions received less pity, were perceived as more socially disruptive, and were blamed more. Thus, if actual interaction with these victims occurred, more negative social reactions would be a likely result.

Social Network Member Affect

Attributions about the controllability of events or stigmatizing conditions also elicit particular affective reactions in others. In fact, the pattern of results in a number of studies, some employing structural equation modeling, has strongly supported Weiner's hypothesized motivational attribution-affect-helping pathway (see Weiner, 1985). Specifically, the consistent finding in studies investigating the influence of the affect elicited by victims is that controllable events give rise to anger, which in turn, evokes unwillingness to help, whereas uncontrollable events give rise to pity, which in turn, evokes help-giving (Betancourt, 1983; Reisenzein, 1986; Schmidt & Weiner, 1988; Weiner, 1980a, 1980b; Weiner et al., 1988). Moreover, when the onset of events is perceived as uncontrollable, but the alleviation of suffering is perceived as within the control of individuals (e.g., through coping efforts), anger and unwillingness to help are elicited if victims do nothing to help themselves, whereas pity and helping are elicited if victims do actively coping (Schwarzer & Weiner, in press). Thus, attributions about both the origin of the victim's problem and its solution (Brickman et al., 1982) appear to be important determinants of the affective response, and hence the negative social reactions of others.

One recent study took a slightly different slant and helps to elucidate the ways in which inconsistent (i.e., both positive and negative) reactions to victims may develop. Specifically, Sacco and Dunn (1990) investigated the ways in which others differentially explain the successes and failures of hypothetically depressed and nondepressed people, and how these attributions relate to affective and behavioral reactions following a request for help. Their results suggested that others attribute more internality, stability, globality, and controllability to depressed than nondepressed people for failures, whereas more external, unstable, specific, and uncontrollable attributions are made for successes of depressed versus nondepressed persons. As a result of these attributions, high degrees of both anger and concern were elicited by the depressed person following a request for help. Behavioral responses to the request for help were determined by the affective reactions elicited by the attributions, but depended on the specific dimension assessed. That is, no differences were found in terms of willingness to help the depressed versus nondepressed person, probably because anger and concern are conflicting emotions. However, desire for future contact was significantly less for depressed than for nondepressed targets. Therefore, a depressed person may experience confusion regarding others' true reactions: Others are willing to help a depressed person when help is requested, but are also likely to avoid future contact.

Social Network Member Feelings of Helplessness and Frustration

Wortman and colleagues (Dunkel-Schetter & Wortman, 1981, 1982; Wortman & Dunkel-Schetter, 1979; Wortman & Lehman, 1985) have discussed the importance of helplessness and frustration in network members with respect to negative social

reactions to victims. In particular, they have hypothesized that if the objective characteristics of a situation or the displays of victim distress are overwhelming to potential support providers, the resulting social responses are likely to be negative. Although there is not a substantial amount of direct empirical evidence for these assertions, three studies help to illustrate the effects of network members' feelings of helplessness and frustration on negative reactions to victims.

First, in the Dunkel-Schetter et al. (1988) study described earlier, the results suggested that the more subjects perceived their telephone interaction partner to be deviant, the greater the feelings of helplessness they experienced. Feelings of helplessness, in turn, were associated with less willingness to interact with the target in the future, forming a less favorable impression of the target, and experiencing more negative feelings during the interaction.

The second study used transcripts to simulate interactions with depressed people in a two-trial design (Winer et al., 1981). On the first trial, these researchers replicated the findings that negative reactions to depressed people occur. In the second trial, Winer et al. (1981) demonstrated that this effect was enhanced by the lack of improvement in the depression displayed by the target. Specifically, if the target did not show improvement from the first to second exposure, more rejection was seen.

In the third study, Notarius and Herrick (1988) examined the association between a helper's response style and her affective reactions following a face-to-face interaction with a depressed confederate. They found that helpers who acknowledged their depressed partner's mood and relied on supportive listening techniques (e.g., expressions of empathy, encouragement), were significantly less depressed themselves after the interaction than helpers who relied on providing advice, idle conversation, or distracting the confederate from focusing on the dysphoric mood by joking. In addition, they found that the latter helpers were significantly less willing to engage in future interaction with the depressed confederate. Notarius and Herrick (1988) suggested that the depressed mood and rejection by these helpers may have arisen from a sense of helplessness at the task of alleviating another person's depressed mood, and that the unwillingness to engage in future interaction may have been a result of a desire to avoid a social situation in which they would feel helpless (Notarius & Herrick, 1988). Thus, those who were invested in alleviating their partner's distress apparently felt helpless after their failure to have an effect, and thus, more rejecting of the prospect of future interaction.

The helplessness and frustration of the potential helpers in the Notarius and Herrick (1988) study is reminiscent of the argument of Coyne et al. (1988) regarding the overinvolvement of network members. Specifically, Coyne et al. (1988) argue that when network members are highly invested in the victim's outcome, they become intrusive and demanding, and later, critical and hostile. These negative reactions occur, in part, because continued displays of distress by

the victim come to be interpreted as signs that support is inadequate, leaving the network member feeling helpless and frustrated.

Mere Presence or Occurrence of Victim Status

There are a handful of studies that suggest that the victim and social network member factors we have discussed contribute to negative social reactions, but are not necessary to elicit them. For example, in those studies investigating the responses of others to depressed persons, some have found evidence of rejection in the absence of any measurable affective effects on the interaction partners (e.g., Gottlib & Robinson, 1982; Howes & Hokanson, 1979). In these studies, it appears that something about the direct exposure to depressed persons itself led to the rejection from others (Gurtman, 1986).

Other studies also suggest that the mere presence or occurrence of a victim status is sufficient to lead to negative reactions. For example, two aspects of the Silver et al. (1990) study described earlier indicated that mere exposure to cancer patients resulted in negative social reactions. First, interaction partners of cancer patients communicating no information about the distress they were experiencing over their cancer demonstrated significant behavioral avoidance and expressed little willingness to engage in future interaction with them, indicating that it was not the communication of distress per se that was solely responsible for eliciting negative reactions. Second, Silver et al. (1990) found that even when cancer patients said they were not distressed or presented a balanced picture, they elicited significantly more discomfort, distress, and avoidance in interaction partners than did confederates who portrayed a healthy person.

Meyerowitz et al. (1990, Study 1) also found that interactions with apparent cancer patients were more negative than interactions with apparently healthy individuals, but these results were more subtle. In this study, subjects had a conversation with a confederate who was described to some of them as a cancer patient. The results suggested that there were no differences on the behavioral measures or subject self-reports of reactions to the conversations (i.e., comfort, concern, liking) between the conditions. Differences did occur, however, on the confederate and observer ratings of the positivity of the conversation, which indicated that subjects who believed they were speaking with a cancer patient were more negative in tone during their interactions. What is most intriguing about these results is that neither the confederate nor observers could pinpoint the exact qualities of the interactions that had been different. On the basis of further exploratory analyses, Meyerowitz et al. (1990, Study 1) found that these subjects reported conflicting reactions around the interaction. For example, they reported being simultaneously comfortable and anxious during the conversation. Meyerowitz et al. (1990, Study 1) concluded that these conflicting reactions led to a display of subtle nonverbal differences in the interactions with cancer patients.

An exception to those studies that find that the mere presence or occurrence of a victim status is sufficient to elicit negative social reactions is Winer et al. (1981). The results of this study showed that it was the victim's depression, and not the occurrence of an event, that led to negative responses. However, the two events utilized in this study were a relationship break-up and nonadmittance to law school, which may be less likely to cause discomfort in subjects than events like depression, cancer, or AIDS. Therefore, mounting evidence suggests that in many cases the mere occurrence or presence of a victim status is sufficient to elicit negative social reactions, and that this might be due to the discomfort aroused when interacting with a victim of a negative event.

SUMMARY AND CONCLUSIONS

This chapter grew out of earlier work on the victimization perspective which suggested generally that network members often respond in unhelpful and negative ways to victims of life events. We distinguished ineffective support attempts from the negative responses of network members, and integrated several bodies of research in order to elucidate the determinants of negative social reactions. The negative reactions identified include rude or insensitive remarks, negative-affective reactions, negative evaluations, victim blame and derogation, physical avoidance and rejection, and discrimination. The determinants of negative reactions, including both victim and social network member factors, were discussed, as was the possibility that the mere presence or occurrence of a victim status is sufficient to elicit negative social responses. Overall, it appears that victims who are distressed, who are not actively coping with their situation, who appear to be responsible for the occurrence of the condition, and whose situation leads to feelings of helplessness and frustration in others, are most likely to elicit negative social reactions.

Undoubtedly, other determinants of negative social reactions to victims exist, but they have yet to be addressed empirically. Two such determinants are the nature of the relationship between the victim and network member, and the type of victimization that has occurred. It was noted earlier that the likelihood of experiencing negative reactions will probably vary with the nature of the relationship between the victim and network member (Dakof & Taylor, 1990; Dunkel-Schetter & Skokan, 1990). One might argue, for example, that victims would be more likely to elicit negative reactions from strangers or acquaintances than they would from more intimate ties. This makes sense intuitively, however, some of the research that was discussed suggests that close ties may be just as likely to respond in a negative fashion. For example, Lichtman et al. (1985) found that the daughters of breast cancer patients were the people most likely to react negatively to the cancer diagnosis. In addition, Winer et al. (1981) found that rejection of depressed persons was greatest when they did not improve over time, and close ties are likely to be those who witness this lack of improvement. Moreover, close ties may be more

likely to feel helpless and frustrated by an apparent lack of improvement on the part of the victim (Dunkel-Schetter & Wortman, 1982).

Gottlieb (in press) has argued that network members may sometimes respond in a negative fashion in order to serve their own emotional needs. For example, if network members experience a great deal of distress over the victimizing event themselves, negative responses such as physical avoidance may be a way to minimize their own distress. Earlier we suggested that in most cases, egoistic or self-serving motivations might underlie negative social reactions, whereas positive social reactions are probably altruistically motivated (Batson et al., 1983). Montada (this volume) suggests that altruistic motivations might be elicited when victims are perceived as suffering an undeserved fate or harm. Furthermore, Betancourt (1990) recently showed in the context of altruistically motivated behavior, that perceived controllability for specific events significantly diminished when a helper approached the situation from an empathic rather than an "objective" perspective. Thus, the degree of empathy network members have may affect the attributions they make for the cause of the event, which may determine their initial motivation to help, which may then determine their responses to victims. The conditions under which network members will be empathic, or will hold egoistic versus altruistic motivations are fascinating areas for further empirical work, as are the relationships of these variables to subsequent social responses to victims.

The type of victimizing event might also determine the extent to which network members respond in a negative fashion. One distinction that Dunkel-Schetter and colleagues have made with respect to support provision and whether support attempts are perceived as helpful or ineffective, is between threat/loss and challenge events (Dunkel-Schetter et al., in press; Dunkel-Schetter & Skokan, 1990). For example, behaviors reported to be particularly unhelpful in threat/loss situations (e.g., cancer, AIDS, bereavement) are minimization or trivialization of the event, and closing off communication about the event. In contrast, with certain challenge events (e.g., a diabetic's adherence to their strict dietary regimen), talking *too much* about the situation is often viewed as particularly unhelpful (Dunkel-Schetter et al., in press). In addition to this distinction, the specific event may be an important determinant of negative reactions because people have varying degrees of past exposure to various events (Dunkel-Schetter & Skokan, 1990).

Other authors have also distinguished between types of events (e.g., Cutrona & Russell, 1990; Weiner et al., 1988). For example, Weiner et al. (1988) have differentiated events that are "physically" versus "mentally behaviorally" based, and have found that those perceived as physically based (e.g., blindness, paraplegia, Alzheimer's disease, cancer) elicit more positive social reactions, whereas those perceived as mentally behaviorally based (e.g., obesity, drug addiction) elicit more negative social reactions.

An even more refined listing of the characteristics of events is provided by Jones et al. (1984), who discuss six characteristics of stigmas, and the different sorts of effects they may have on those interacting with them: concealability (e.g., is the

stigma hidden or obvious?); course (e.g., does the course change over time and what is its ultimate outcome?); disruptiveness (in terms of social interaction and communication); aesthetic qualities (e.g., how repellent, ugly, upsetting is it?); origin (e.g., under what circumstances did it originate? Who was responsible?); and peril (e.g., what kind of danger does the stigma present, how imminent and serious is the threat?).

In light of these characteristics, the diagnosis of AIDS is an especially complex and devastating event. It combines the most unfavorable of these stigma qualities, including the fact that it is an infectious life-threatening illness that is usually associated with either a homosexual lifestyle or intravenous drug use, two dimensions to which many individuals respond negatively (Herek & Glunt, 1988). One study has found, in fact, that the association of AIDS with the homosexual lifestyle is an important predictor of negative social reactions, more important than the fear of contracting the disease (Pryor, Reeder, Vinacco, & Kott, 1989). Another study (Montiada & Figura, 1990) found that the tendency to socially isolate AIDS victims was associated with the perceived risk of casual contact and the extent to which they were blamed for their victim status. These two factors, however, were highly related to social prejudices against groups at risk for AIDS. Thus, the diagnosis of AIDS carries with it a number of symbolic issues to which others might respond negatively. This might be why Weiner et al. (1988) found that the stigma of AIDS did not fit neatly into either of their physically based or mentally-behaviorally based categories.

A more general theoretical point might be made in closing. While this chapter has focused on negative social reactions to victims of life events, many of the reactions, as well as their determinants, have been discussed in terms of the stigmatized (Goffman, 1963), the deviant (Freedman & Doob, 1968), the marked (Jones et al., 1984), and those who are targets of prejudice and discrimination (see Crosby, Bromley, & Saxe, 1980). Therefore, our attempt to examine determinants of negative social reactions to victims may actually extend more broadly. A task of future research, then, is to determine the degree of overlap of victimizing negative events with these other conditions, and ideally, to find a better term than "victims" to refer to people in various kinds of unfortunate circumstances.

We are all disadvantaged in one way or another, at some time, or in some way, be it physically, emotionally, socially, or because of our history or current circumstances. Thus, most of us have been the targets of negative social reactions of some kind. It is our belief that the processes described herein are broad and far-reaching. In this sense, it is exciting to begin to explicate the specific features of negative social reactions to misfortune and their determinants.

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