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The Dangerous Role of Silence in the Relationship Between Trauma and Violence: A Group Response, **by Suzanne B. Phillips, Psy.D., ABPP, CGP, FAGPA**

Estimated Time to Complete this Activity: 90 minutes

Learning Objectives:
The reader will be able to:
1. Describe using three empirical examples the way in which violence causes trauma and unvoiced, unassimilated trauma manifests as more violence.
2. Describe the way in which silence is central to at least four of the following: the neurological, existential, developmental, interpersonal, and cultural impacts of trauma from violence.
3. Describe the way in which silence after traumatic violence intensifies the impact.
4. Describe the potential of group experience to disrupt the cycle of violence leading to more violence by making room for breaking the silence, for bearing witness and giving voice to violence.
5. Provide one example from the article of the potential of a group experience to disrupt the dangerous role of silence in the aftermath of trauma.

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The Dangerous Role of Silence in the Relationship Between Trauma and Violence: A Group Response

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ABSTRACT

This article considers that somewhere in the space between violence and trauma is dangerous silence. Silence intensifies the impact of trauma, and trauma that goes unspoken, un-witnessed, and unclaimed too often "outs itself" as more violence to self or others. Relevant empirical evidence on the impact of civilian interpersonal violence, combat trauma, school shootings, bullying, and domestic violence confirms this tragic cycle. Crucial to addressing the danger of silence in this cycle, the article examines the centrality of silence existentially, neuropsychologically, psychologically, developmentally, interpersonally, and culturally in relation to violence. The bridge to voicing and assimilating the unspeakable is empathic connection with others. Drawing upon two different types of group programs, the article demonstrates that group can serve as that bridge. Group process has the potential to undo the dangerous role of silence in the relationship of trauma and violence.

What makes silence dangerous in the aftermath of violence is that it invites and intensifies trauma. It precludes the safety, remembering, grieving and connection necessary to heal from traumatic events. According to van der Merwe & Gobodo-Madikizela (2008) "trauma will out" in one way or another, even if

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it is silenced or denied (p. 33). Cathy Caruth (1996) tells us that trauma haunts the survivor. It "imposes itself" repeatedly, be it in nightmare, bodily experience, or behavior (p. 4). Trauma is "always a story of a wound that cries out" to be heard and to be assimilated (p. 4). As such, I suggest that unspoken, unwitnessed and unclaimed trauma from violence "outs itself" as violence to self or others, a vicious cycle that is tragic.

The goal of this article is to make this reality clear and to consider the potential of group experience to disrupt this cycle by making room for trauma to be held, witnessed, understood, enacted, voiced, and shared on many levels and in many ways. I begin with a brief look at the empirical evidence that underscores the role of violence in causing trauma and the nature of unvoiced and unassimilated trauma in manifesting as more violence. From there, I will consider the centrality and complexity of silence in the interconnection of violence and trauma. To consider the varying ways that group process addresses the silent scars of violence, I will draw upon my own experience with varied group experiences, including a program for suicide survivors and an informal group with military women.

There have been theoretical considerations that confirm the relevance, stages, and efficacy of group in the aftermath of trauma (Herman, 2007; Klein & Phillips, 2008; Klein & Schermer, 2000) as well as descriptions of evidenced-based group interventions (Buchele & Spitz, 2004; Lubin & Johnson, 2008; Mendelsohn et al., 2011). What I propose here is that varied types of group experience, even if not specifically designed as trauma treatment, serve to break the silence imposed by violent trauma and facilitate healing that reduces the potential for trauma to escalate more violence. "The self is both autonomous and socially dependent, vulnerable enough to be undone by violence and yet resilient enough to be reconstructed with the help of empathic others" (Brison, 2002, p. 38).

THE ROLE OF VIOLENCE IN CAUSING TRAUMA

Violence is defined as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in, or has a

high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation" (World Health Organization, 2003). It is estimated that violence takes the lives of more than 1.5 million people annually, with just over 50% due to suicide, 35% due to homicide, and just over 12% as a direct result of war or some other form of conflict (World Health Organization, 2008).

Recent research on the effects of interpersonal violence on psychological outcomes in men and women corroborate earlier studies and underscore the impact. Using data drawn from the National Comorbidity Survey Replication Study involving 5,692 women and men, Iverson and colleagues (2012) found that approximately 46% of the women and 42% of the men reported one or more types of interpersonal violence in their lifetime. Women were more likely to experience kidnapping, physical assault by an intimate partner, rape, sexual assault, and stalking, whereas men were more likely to experience mugging or physical assault by someone other than parents or an intimate partner. The results revealed that interpersonal violence is associated with risk for many mental disorders and attempted suicide.

Further evidence of the impact of violence are the latest studies reported by the National Center for Post Traumatic Stress that suggest that 10–18% of combat troops serving in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) have probable post traumatic stress disorder (PTSD) following deployment, with continued prevalence over time. Adding to this, for both female and male veterans, the risk of developing PTSD from sexual assault in the military is similar in magnitude to the risk of substantial combat trauma (Kang, Dalager, Mahan, & Ishii, 2005), and female and male veterans with a history of military sexual trauma (MST) are more likely to meet criteria for depression (Kimerling et al., 2010).

TRAUMA RESULTING IN VIOLENCE TO SELF

Given the degree of trauma suffered in combat and from MST, there is evidence that such trauma often results in violence to self. Statistics indicate that nationally, one in every five suicides is a veteran (Hargarten, Burnson, Campo, & Cook, 2014). Weiner, Richmond, Conigliaro, and Wiebe (2011) found that 25% of all

female deaths in the military are attributed to suicide. Suicide is the leading cause of death among military women.

Echoing the danger of silence, one veteran who lost his friend to suicide shares, "The bad part about it is that he didn't give us a chance to talk. I mean, if he had just said, 'Hey, Clint, I'm thinking about doing this.' I could have said, 'Hey man, I'm thinking about doing it too. You got to have that conversation. You have to tell somebody, as embarrassing as it is,'" he said. "All I ever considered when I thought about [suicide] was the guilt I was feeling and just wanting a way out, wanting to not have those memories anymore" (Hargarten et al., 2013).

VIOLENCE AND TRAUMA RESULTING IN VIOLENCE TOWARD OTHERS

In addition to self-directed violence, aggression perpetrated by veterans has become a concern in the media, the judicial system, and clinical settings (Alvarez & Sontag, 2008; Taft et al., 2009). Killgore and colleagues (2008) in surveying over 1,000 Operation Iraqi Freedom veterans found that exposure to violent combat, killing another person, and contact with high levels of human trauma were predictive of greater risk-taking, including greater alcohol use and physical and verbal aggression to others, even before returning home.

Recent research finds that PTSD symptom severity adds to and is a much stronger predictor of aggressive behavior than the impact of combat alone (Hoge, Auchterlonie, & Milliken, 2006). Given the military code of silence, the expectation that civilians will not understand, and the anger and avoidance associated with PTSD, the finding that PTSD exacerbates the impact of combat exposure becomes understandable.

A 2006 study in the *Journal of Marital and Family Therapy* looked at veterans who sought marital counseling at a Veterans Affairs medical center in the Midwest between 1997 and 2003. Those given a diagnosis of PTSD were "significantly more likely to perpetrate violence toward their partners," with more than 80 percent committing at least one act of violence in the previous year and almost half committing at least one severe act (Alvarez & Sontag, 2008).

A 2004 study by the United States Department of Justice of the U.S. veteran prison population found that U.S. veterans were less likely than the general population to offend, but if they were in prison, it was for violent and sexual offenses. As such, it is important to recognize that such violence often results in a legacy of domestic violence that adds to the evidence of violence suffered and repeated. Michael Paymar (2000), author of *Violent No More*, reports that, "Children are present during 80% of the assaults against their mothers" (p. 1). The most recent research on domestic violence suggests that exposure to interparental violence (IPV) leaves one at risk of both later perpetration and victimization, with the exposure history of one's partner adding to the risk (Fritz, Slep, & O'Leary, 2012).

The cycle of violence and unspoken trauma resulting in more violence is also found in the civilian population. Two studies on threat assessment co-directed by Robert Fein and conducted by the U.S. Secret Service were reported in the February 2014 *Monitor on Psychology;* the studies consider those people who have already been violent in attacks on public figures and school shooting cases (Fein & Vossekuil, 1999; Vossekuil et al., 2002). Fein indicates that "targeted violence is the end result of an understandable and often discernible process of thinking and behavior—people just don't snap" (p. 38). What is of great concern is that a common theme reported by attackers includes an experience of loss, failure, or public humiliation in the days or weeks before the attack. Often the attackers felt that they had been bullied or persecuted by others. Commenting on this in terms of threat assessment, Robert Fein suggests that when normal ways of coping with stress don't work and life feels unbearably stressful, some resort to violence (Miller, 2014).

Bullying-related suicides in the United States and other countries add to this picture. Yale University research, considering 37 studies from different countries, suggests that bully victims are between two to nine times more likely to consider suicide than non-victims (Kim & Leventhal, 2008). Underscoring the role of silence in the trauma to violence connection is a study of more than 3,000 high school students, which reports that even when students were personally threatened, they remained silent. Of the

12% who actually reported being threatened at school, only 26% told a teacher or school official (Miller, 2014).

The recent film *Strain* (Chang, Havener, & Armstrong, 2012)), captures this dangerous silence. It is an 11-minute anti-bullying film that tells the story of two friends. One is bullied while the other (one of the filmmakers) watches but remains silent. The bullied friend dies by suicide (Breschisci, 2013). The film is the silent friend's attempt to bear witness and send a message to avert such tragedy. In a unique example of the medium being the message, this film uses silence in a poignant way. Only background sounds and noises are heard—there are no voices.

THE CENTRALITY OF SILENCE IN THE IMPACT OF VIOLENT TRAUMA

Existentially, neuropsychologically, psychologically, developmentally, interpersonally, and culturally, violent traumatic events silence us and those around us. Unclaimed and unvoiced, such violence often "outs" as more violence.

Existentially

Existentially, violent trauma is one that cannot be comprehended. Trauma feels unspeakable because of the inadequacy of language to convey the experience. Philosopher and survivor of rape and attempted murder, Susan Brison (2002) suggests that trauma introduces a "surd"—a nonsensical entry into the series of events of our life, making it difficult to carry on with the series. In Latin, "surd" comes from "surdus" meaning deaf, silent, stupid. Linguistically, a surd is a voiceless sound. In math, it is an irrational number. For Brison, the violent rape that was intended to kill her was an event that fit no predictable pattern and "more importantly it was a loss of sound—silence." She asks, "How do we speak the unspeakable?" (p. 103).

Neuropsychologically

Faced with a life-threatening event, our human neuropsychology takes over. Most people do not have a coherent story of what has happened because they have been busy surviving. The right

hemisphere of the brain associated with survival behaviors and emotional expression is activated and the left verbal-linguistic part of our brain is suppressed. The body prepares to respond with the survival reflexes of fight, flight, and freeze.

Given the nature of this response, it is likely that most people who have experienced traumatic events will have lingering traces manifested in symptoms of hyperarousal, intrusion, numbing, avoidance, and negative thoughts and moods. Rape survivor Nancy Raine (1999) describes the experience as follows: "The instant I was free the seed of terror that had been planted in those hours burst open spitting out an uncharted island where I was now stranded.... Terror overwhelmed me" (p. 15). Because violent events are encoded under fight/flight/freeze conditions, the memory of the traumatic event is not like the memory for ordinary events that can be told as narrative with a beginning, middle, and end. Memories are experienced as fragments of highly charged visual images, bodily feelings, tactile sensations, or sensory reactivity to reminders of the event. Traumatic memories are the imprints of trauma without words. "Words had no referents and no beauty of their own. Memories were drained of meaning because the person who had them no longer existed" (Raine, 1999, p. 14).

Psychologically—The Loss of the Core Self

Adult onset trauma is what Gloria Boulanger (2007) refers to as being "wounded by reality," and which she describes as a dismantling of the known self—one's physical capacities, cognitive ability, time, and verbal and emotional connections to others. Boulanger describes victims as suffering a "loss of the sense of agency," that is, the ability to think, problem solve, make things happen. In work with rape victims, I have come to know that the sounds, smells, and sights that serve as trauma triggers bring back not only terror but a sense of shame and self-blame for not fighting, for being victims. So many ask, "How can I be a victim?"

Adding to this is a loss of time continuity, of feeling frozen in the traumatic moment without a sense of the past, an interest in the present, or access to the future. Both the self-blame and the feeling of being lost in time become barriers to thinking, much

less talking, about the horror endured. "Survivors instinctively understand that what they experience is different in kind from all other experience. This difference seems to destroy the threads of narrative the moment one tries to weave them" (Raine, 1999, p. 112).

Developmentally—The Unclaimed Self

Compared to adult onset trauma, relational or developmental trauma is the wordless horror of child abuse, the assault on the body and mind of a child that necessitates dissociation as defense because the chaotic, convulsive flooding of unregulated affect is beyond what can be endured or represented (Bromberg, 2011). Early on, it must be split off into a self-state that cannot coexist in a single state of consciousness without destabilizing self-continuity. From there, it stays split off as a dissociated mental structure that vigilantly anticipates the "shadow" of trauma before it can arrive unexpectedly. Dissociation turns the mind into a smoke detector and life into an unlived waiting period. Silence is intrinsic to the legacy because experiences have been invalidated by significant others and language has been used to translate them out of experience.

Interpersonally

Relevant to the centrality of silence in the aftermath of violent trauma is the loss of community and connectedness. Trauma isolates us from our familiar self as well as from others. Stolorow (2007) describes emotional trauma with the accompanying feelings of "singularity, estrangement, and solitude" (p. 49). Reflecting the sense of losing touch on many levels, rape survivor Brison (2002) describes, "The trauma has changed me forever, and if I insist too often that my friends and family acknowledge it, that's because I'm afraid they don't know who I am" (p. 21).

Often the link between violence, trauma, and more violence is a function of the fact that "Trauma won't be heard." Drawing on the research of Harber and Pennebaker (1992), Bloom and Reichert (1998) state,

> Bearers of disturbing information and negative emotions are suppressed in various ways. Listeners switch the topic away from trauma. They attempt to press their own less upsetting perspective of the trauma upon the victim. Listeners tend to exaggerate the victim's personal responsibility in the traumatic situation. If these strategies do not work to get the victim to stop talking, then the listener will avoid contact with the victim altogether. (p. 89)

Included in this social response is that of "the bystanders." Violence is not just a function of the dyad of perpetrator and victim (Bloom & Reichert, 1998). It includes the bystander whose reaction bears on the degree of violence. If we consider that unspoken and unheard trauma potentiates more violence because silence implies compliance, then there are no innocent bystanders (Phillips, 2014).

A painful example is the devastation and danger of being silenced as a survivor of suicide. In the aftermath of losing their son to suicide, Bill and Beverly Feigelman (Feigelman, Jordan, McIntosh, & Feigelman, 2012) describe a bereavement group at which a parent is told that the group is only for those whose children have died by natural means. They report the case of a neighbor who crosses the street in order not to speak to a parent suicide survivor. They describe the silence borne of assumed judgment, self-stigmatization, and the social ambiguity that leaves some bystanders not knowing what to say.

Culturally

Be it the culture of an organized religion, a military setting, or an extended family, dangerous silence often reflects a code embraced by victim and perpetrator. In what has been termed the "sacred silence" of the church scandals, the perpetrators exploited the confused and frightened silence of children and the idealization of congregations to cover atrocity (Cozzens, 2002). There were no words or signs of the "soul murder" (Shengold, 1989).

The military code of silence takes a toll on those who carry home from war the memories, moral wounds, and imprints of the horror they dare not share. Be it out of shame, guilt, or fear of contaminating those they love, silencing "the things that they carried" too often unfolds as violence to self or others (O'Brien,

2009). From another perspective, this code of silence has been misused by perpetrators of military sexual trauma. Perpetrators have exploited rank and characterized silence as strength to violate others and then have disavowed their crimes. As described in the 2013 documentary film, *The Invisible War,* seeking help by victims is physically, culturally, and emotionally dangerous (Ziering, Barklow, & Kirby, 2012).

In the silence of generations who have known atrocity, like survivors of the Holocaust, there is the mix of needing to remember, wishing to forget, and protecting future generations. The result is a haunting legacy. As Gabrille Schwab (2010) says of her childhood in postwar Germany, "Words could be split into what they said and what they did not say...I had a vague sense of something deadly, of words filled with skeletons" (p. 43).

GROUP RESPONSES TO SILENCE

Violence traumatizes people and destroys language. The silence that often results compromises healing, assaults connection, and perpetuates more violence. As such, the group modality, in many configurations, becomes an invaluable resource and response. (In the examples that follow, information has been deleted or altered to protect confidentiality.)

In *Narrating Our Healing*, Chris N. van de Merwe and Pumla Gobodo-Madikizela (2008) draw on their experiences with the Truth and Reconciliation Commission (TRC) in South Africa. They remind us that telling the story of trauma is difficult, and that it is not in the simple sharing that healing begins but in being listened to with empathic concern. Stolorow (2007) refers to the need for an intersubjective context, a relational home to come into the language of emotional experience.

UNDOING THE SILENCE OF DEVASTATING LOSS

The loss of a loved one by suicide is devastating. It not only reflects the victim's violence to self from unbearable psychic pain, it unfolds into considerable trauma for the loved ones. Complicating and exacerbating the traumatic loss is silence.

Included in a research survey of 575 cases of parents who lost children from traumatic and non-traumatic causes, 462 were parents of children who died by suicide (Feigelman et al., 2012). Their responses to open-ended survey questions revealed experiences of stigma and stigmatization often expressed in subtle and non-obtrusive ways like silence and dismissal. As one father reports,

> People never said anything really bad to me [after Bobby hung himself]. It was not what they said; it was what they didn't say. Some people who I thought would offer solace remained quiet. And most people just said nothing [after my son's death] and seemed to try to avoid any discussion. It was as if my son never existed. (p. 39)

Most survivors are plagued by the question of why and feel shame, anger, guilt, and fear of judgment, both of self and loved one. Edwin Shneidman (1972) suggests that it is as if the person who commits suicide leaves his psychological skeleton in the survivor's emotional closet. The pain of this situation is often heightened by the ambiguous or withheld responses of others. As such, too many suicides remain hidden and silenced by family members. Because the suicide of a family member is a significant suicide risk factor for surviving family members, it is crucial we help survivors find a voice that can be heard by others.

INTERNATIONAL SUICIDE SURVIVOR DAY

> "If someone speaks, it gets lighter." (Freud, 1916–1917/1958, p. 407)

One of most valuable and utilized recommendations for suicide survivors has been suicide-survivor groups. Whether they are peer or professionally run, or even virtual groups, they have proven to be valuable for healing (Cerel, Padgett, & Reed, 2009; Feigelman et al., 2012; Garvin, 1997).

My own group experience with suicide survivors has been as a volunteer group leader on International Survivors of Suicide

Day. Leaders are a mix of professionals and those who themselves have suffered a loss. This annual event is held in cities and countries throughout the world on the Saturday before Thanksgiving, the start of the holiday season. On that day, 50 to 100 people gather to share an informal lunch with other survivors; view a film of a "leader-led survivor group"; listen to questions asked and answered by a trauma expert on the film; and in the afternoon, participate in homogeneous (loss of child, spouse, sibling, etc.) leader-led breakout groups (Feigelman et al., 2012).

For me, this is an example of how different configurations of group experience address multiple and complex needs. The survivors experience a large group event, an informal table group of mixed survivors, a psychoeducational group experience, the shared experience of viewing a survivor group on film, and the experience of being in small homogeneous groups. As such, this full-day group program offers many transformative aspects of trauma group intervention: safety, bearing witness, psychoeducation, validation and containment of feelings, finding a voice, altruism, and hope. Inherent in these aspects of group is the opportunity to move from silence to sharing in the context of connection.

BEARING WITNESS

I join a lunch table where I see a man sitting alone and two other women speaking. I introduce myself as a psychologist who has worked with survivors, whose two friends have suffered loss from suicide, and who comes each year to be one of the leaders. The women introduce themselves and share their losses of a few years ago. The man watches. When his young adult daughter arrives, she speaks for both about the loss of her mother a month earlier and the refusal of her brother to speak about it. What will unfold from this informal table discussion as more survivors fill the table is normalization of the fear of coming to such an event and validation of the difficulty of dealing with a suicide.

What will become apparent is the reality of different family reactions and intergenerational conflict regarding loss and expressions of grief. People will reveal anger toward family members who criticized them for coming, of the family pressure to keep

suicide a secret, and of the relief of speaking with others who have lived through violent loss by suicide.

PSYCHOEDUCATION AND MEDIA

Media can serve an important role in trauma group work. They not only provide psychoeducation that facilitates normalizing, validating, and self-reflection, they invite identification at a safe distance. They model the power of verbal exchange and permission for differences. As such, they stimulate narrative. Each year, I observe members in the afternoon breakout groups refer to the survivor group in the film as a preface to bringing up a topic like the holidays, children, and so forth, or as a point of comparison with their own experience.

CONTAINMENT

As in other trauma groups, homogeneity fosters cohesion as a function of the commonality of experience. I have observed that such groups allow containment of details, images, and graphic descriptions with less overt retraumatization than heterogeneous groups, particularly in the acute stage of trauma. In the homogeneous groups of parent, sibling, and spouse suicide survivors, there is an invitation for members to say what they have not shared anywhere else. It is implicit in the modeling of those who have been there before that the group is a safe place. In the face of the graphic descriptions of a loved one's suicide, members hold each other with their eyes and often respond with tears that give support and permission to share and be held emotionally. Hearing about another's loss by suicide seems to make it possible to reconsider what they have faced and find a place for what they cannot quite believe.

GIVING VOICE

Suicide is a violent act that resonates in different ways with those who knew and loved the person lost. In my experience, a group that has benefited from this program includes the siblings of a brother or sister who has died by suicide. In their research with siblings, Dyregrov and Dyregrov (2005) call them "the forgotten

bereaved" (p. 714). These researchers report that siblings in this situation rarely share outside the home for fear of stigma and rejection. In the home, they often restrain themselves from mentioning the death even though they have a need to speak with and be comforted by their parents.

Sitting together in a group on Suicide Survivor's Day, siblings talk about the fear of upsetting their bereft parents as well as the difficulty of being silent. Often they express anger toward the sibling who has died by suicide for creating such pain for everyone. They wonder if they were even loved or trusted by that brother or sister. Many register the fear of being like the sibling and possibly getting that desperate, asking, "Could I do that?"

As the leader to the sibling group, I have listened and at times invited clarification or interpretation of the non-verbal cues of members that seem to validate the shared feelings. Sometimes, I have invited group consideration of differences or confusion. Sometimes, I have used psychoeducation to clarify a topic like the causes of suicide and the psychic pain that it reflects. Although unknown to each other, sibling survivors embrace the opportunity to ask questions to learn what others have faced and how they have responded. Often, they reveal for the first time in these groups that they knew something about their sibling they feel they should have shared or acted upon. At such times, there is often mutual support for feelings of guilt, as well as validation of the common but unrealistic notion that they could have prevented the suicide. Stolorow (2007) would describe this group process as forming "a connection with a brother or sister who knows the same darkness" (p. 49).

ALTRUISM

The behavior of the quiet father at the lunch table mentioned above is an example of the power of group process in a one-day group experience. As it happens, this quiet father was in my breakout group that afternoon, and in stepping up to care for someone else, he became one of the most verbal members. On hearing another man with a frozen face share without emotion that his wife had taken her life the week before, the quiet father broke his silence to disclose the details and pain of his own

wife's public suicide. The message of this unexpected disclosure seemed to be, "It feels unbearable, I know, but somehow we will find a way." He added that he appreciated that this was a group of spouses because he could finally speak without his children having to hear or cope with what he had seen. The others nodded in agreement. As happens in a group, the giving and getting is often unexpected but powerful and mutual.

International Survivors of Suicide Day is not unlike other full-day group programs offered in the aftermath of trauma, such as Care of Caregivers, Couples Connection, and Family Resiliency Programs for which there have been qualitative evaluations of effectiveness in reducing the primary and secondary impact of trauma (Klein & Phillips 2008; Underwood, 2008). What is important to consider is the transformative potency of group programs that may only last for a day. While many people will need more intervention to integrate violent trauma, reaching out in a group that requires one day of involvement may be a risk many can handle, one that holds potential for starting a healing process.

BREAKING THE MILITARY CODE OF SILENCE

When asked by organizations to offer informal groups for military women to facilitate their readjustment from military to civilian life, I intended to give those women an opportunity to come together and discuss related issues. I knew from the literature (Benedict, 2009; Caplan, 2011; Katz, Bloor, Cojucar, & Draper, 2007) and my own experiences speaking with and writing about military women, that reentering civilian life was a jolt. There was the need to make up for lost time away from children, the strain of redefining relationships, and the difficulty of putting aside all that they carried in order to be physically and emotionally present (Buchele & Spitz, 2004; Phillips, 2012a, 2012b, 2013; Phillips & Kane, 2008). For these groups, I had prepared some psychoeducational and humorous talking points, but I never used them.

The women who came together did not know each other. They spanned years and service from WW II to Desert Storm and Kuwait, as well as to Operation Iraqi Freedom and Operation Enduring Freedom in Afghanistan. Most were veterans; a

few were active reservists. They were a mix of single, married, and divorced women. The rationale for the group was to offer them a place to be with other veterans or military women who understood issues of reintegration to civilian life. What unfolded across different groups was unexpected. They seemed captivated by each others' stories and patient with the latecomers who interrupted or members who walked around with agitation, returning only to respond to someone's issue from across the room. As the facilitator, I was mostly an empathic listener whose presence served to hold the group psychologically, facilitate sharing, and offer validation and support, if needed. I was struck with the way they seemed to search out who they were in the eyes and comments of the others. It is what I had seen in other homogeneous trauma groups, the wish to know and be known by others who have journeyed in a similar way. It is also the need of survivors, for whom violence has disrupted and altered the original sense of self, to have a safe place to find a voice and find self again.

Military women are often placed separately from each other when serving, and so for many, these groups were giving them a female military cohort that they had never experienced. How could they reintegrate into a civilian life without first connecting their experiences with other female veterans? I should not have been surprised that, as they found their commonalities and validated each other's issues, they found a voice for the military sexual trauma that many had suffered, denied, disowned, or acted upon. Having worked with rape victims over many years, I understood the assault to body and mind, the inability to make sense or put words to what had occurred, and the inability to forgive self for being a victim of rape. What was palpable here was the complicated silence that makes MST different from civilian sexual trauma.

As shown in *The Invisible War* (Ziering et al., 2012), when a man or women in the military has been raped, they feel that there is no safe place. There is no one to trust with the horror and often no way to put an end to it, as one fears gossip, retaliation, ostracism, or career destruction. What became striking in these informal group experiences was that in the course of talking about a range of topics, one person often broke the silence about sexual violence by sharing a story she had never told. At

these times, the others listened, some with tears, some validating with similar situations, some saying nothing. A testament to them was their ability to make room for disclaimers and minimize personal experiences by some group members. In one case, a member who had been quiet when the topic was first raised waited until a few groups later to ask if her former homelessness and substance abuse might be connected to the sexual abuse she had put out of her mind and never mentioned.

The benefit of this type of group experience, which invited members to meet informally every few months to have lunch and speak, was actually unexpected. Very different from on-going treatment groups, or even weekly groups with open membership, the occasional gatherings of women seemed to allow them to consider issues on their own terms and time without expectations. They were just talking, and as group facilitator, I was listening, empathizing, noting commonalities, and supporting their connection. Maybe it was this very arrangement that made breaking the silence about military sexual trauma possible.

In trauma response, we understand that often we must adapt to the culture and bring our services to those in need (Klein & Phillips, 2008). One of the realities about female veterans, particularly mothers who feel they have been away from their children too much, is that they take very little time or help for themselves when they return from service. In this case, we were adapting to their culture. Perhaps it lowered the barriers of resistance to meet them on their time and schedule. What was illuminating was that although as veterans some had sought outside private therapy or used the VA for other services, most had never addressed military sexual abuse. Perhaps providing them with a cohort of military women with the overall goal of helping each other was both a trigger for memory and a safe place to share the pieces of the sexual violence suffered.

Surprising for me as a clinician, and perhaps something that is more likely to emerge when military women are meeting together, was an additional, unexpected reason for silence about MST. In addition to the horror, fear, ostracism, and self-blame, it became clear that some women colluded with the silence because they believed they could not own the betrayal of sexual trauma and feel proud of their service at the same time. They loved the

military. They saw it as a definition of self, even as veterans. In one or two cases, there was even talk of staying in the reserves. To own the abuse and get help was to lose something they believed in: "You shut your mouth and pretend it didn't happen because you wanted this your whole life and if you let it get to you—it will be ruined." The challenge for some was not just breaking the silence about the sexual violence, but reconciling to it without disqualifying pride in serving.

There are many things that cannot happen in informal military women's groups that meet over many months. We have no formal evidence of completing the stages of establishing safety, remembering, mourning, and connecting that foster recovery from trauma (Herman, 2007). What we do have is a reflection of enough safety and connection to break the silence of violence in small steps, to verbalize the fears and conflicts, to give voice to what was never said or owned, and to bear witness to these in others. If this was a step closer to dealing with trauma and connecting with organizations that help military members, then it was a step away from violence.

SUMMARY

Somewhere in the space between violence and trauma is dangerous silence. Silence intensifies the impact of trauma and trauma that goes unspoken, unwitnessed, and unclaimed and it often "outs itself" as more violence to self and/or others. One only has to consider the relevant empirical evidence to confirm this tragic cycle. Crucial to addressing the danger of silence in this cycle is understanding of the centrality of silence existentially, neuropsychologically, psychologically, developmentally, interpersonally, and culturally.

The bridge to voicing and assimilating the unspeakable is empathic connection with others. This can take place in varying group contexts, such as a one-day group experience like International Survivors of Suicide Day or an informal group like the military women's groups described above. In varying configurations, group offers a holding environment without shame or stigma in the aftermath of the unspeakable. There, one is heard without

words; one hears others and finds words; and it is safe enough to feel like a victim until one can become a survivor. A group experience has the potential to begin, expand, and facilitate a healing process. As such, group can respond to the dangerous role of silence in the relationship of trauma and violence.

"Without the integration of traumatic events into cultural discourses, individuals as well as society in general stay traumatized" (van der Merwe & Gobodo-Madikizela, 2008, p. 58).

REFERENCES

Alvarez, L., & Sontag, D. (2008, February 25). When strains on military families turn deadly. *New York Times*. Retrieved from http://www.nytimes.com/2008/02/15/us/15vets.html?pagewanted=all

Benedict, H. (2009). *The lonely soldier: The private war of women serving in Iraq.* Boston, MA: Beacon.

Bloom, S. L., & Reichert, M. (1998). *Bearing witness: Violence and collective responsibility*. New York: Haworth.

Boulanger, G. (2007). *Wounded by reality: Understanding and treating adult onset trauma.* New York: Psychology Press.

Breschisci, A. (2013, September 19). Silent anti-bullying short film "Strain" speaks volumes. *Newsday*. Retrieved from http://www.newsday.com/long-island/li-life/silent-anti-bullying-short-film-strain-speaks-volumes-1.6105628

Brison, S. J. (2002). *Aftermath: Violence and the remaking of a self.* Princeton, NJ: Princeton University Press.

Bromberg, P. (2011). *The shadow of the tsunami and the growth of the relational mind.* New York: Routledge.

Buchele, B. J., & Spitz, H. I. (2004). *Group interventions for treatment of psychological trauma.* New York: American Group Psychotherapy Association.

Caplan, P. J. (2011). *When Johnny and Jane come marching home: How all of us can help veterans*. Cambridge, MA: MIT Press.

Caruth, C. (1996). *Unclaimed experience: Trauma, narrative, and history.* Baltimore, MD: Johns Hopkins University Press.

Cerel, J., Padgett, J. H., & Reed, G. A. (2009). Support groups for suicide survivors: Results of a survey of group leaders. *Suicide and Life-Threatening Behavior*, *39*(6), 588-598.

Chang, Y., Havener, D., & Armstrong, C. (2012). *Strain* [Motion picture]. Los Angeles, CA: LeliMelo Productions.

Cozzens, D. B. (2002). *Sacred silence: Denial and crisis in the church*. New York: Liturgical Press.

Dyregrov, K., & Dyregrov, A. (2005). Siblings after suicide—"The forgotten bereaved." *Suicide and Life Threatening Behavior, 35*(6), 714–724.

Feigelman, W. J., Jordan J. R., McIntosh, J. L., & Feigelman, B. (2012). *Devastating losses: How parents cope with the death of a child to suicide or drugs.* New York: Springer.

Fein, R. A., & Vossekuil, B. (1999). Assassination in the United States: An operational study of recent assassins, attackers, and near-lethal approaches. *Journal of Forensic Sciences*, *44*(2), 321-333.

Freud, S. (1958). Introductory lectures on psycho-analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 15, pp. 1-240). London: Hogarth Press (Original work published 1916-1917).

Fritz, P. A. T., Slep, A. M. S., & O'Leary, K. D. (2012). Couple-level analysis of the relation between family-of-origin aggression and intimate partner violence. *Psychology of Violence*, *2*(2), 139-153.

Garvin, C. (1997). *Contemporary group work* (3rd ed.). Needham Heights, MA: Allyn and Bacon.

Harber, K. D., & Pennebaker, J. W. (1992). Overcoming traumatic memories. In S. A. Christianson (Ed.), *The handbook of emotion and memory: Research and theory* (pp. 359-387). Hillsdale, NJ: Erlbaum.

Hargarten, J., Burnson, F., Campo, B., & Cook, C. (2014). Suicide rate for veterans far exceeds that of civilian population. Retrieved from http://www.publicintegrity.org/2013/08/30/13292/suicide-rate-veterans-far-exceeds-civilian-population

Herman, J. (2007). *Trauma and recovery: The aftermath of violence from domestic violence to political terror*. New York: Basic Books.

Hoge, C. W., Auchterlonie, J. L., & Milliken, M. S. (2006). Mental health problems, use of mental health service, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association, 295*, 1023-1032.

Iverson, K. M., Dick, A., McLaughlin, K. A., Smith, B. N., Bell, M. E., Gerber, M. R., et al. (2012). Exposure to interpersonal violence and its associations with psychiatric morbidity in a U.S. national sample: A gender comparison. *Psychology of Violence, 3*(3), 273-287. doi:10.1037/a0030956

Kang, H., Dalager, N., Mahan, C., & Ishii, E. (2005). The role of sexual assault on the risk of PTSD among Gulf War veterans. *Annals of Epidemiology, 15,* 191-195. doi:10.1016/j.annepidem.2004.05.009

Katz, L. S., Bloor, L. E., Cojucar, G., & Draper, T. (2007). Women who served in Iraq seeking mental health services: Relationships between military sexual trauma, symptoms, and readjustment. *Psychological Services, 4*(4), 239-249. doi:10.1037/1541-1559.4.4.239

Killgore, W. D. S., Cotting, D. I., Thomas, J. L., Cox, A. L., McGurk, D.,Vo, A. H., et al. (2008). Post-combat invincibility: Violent combat experiences are associated with increased risk-taking propensity following deployment. *Journal of Psychiatric Research*, *42*(13), 1112-1121. doi:10.1016/j.jpsychires.2008.01.001

Kim, Y., & Leventhal, B. (2008). Bullying and suicide: A review. *International Journal of Adolescent Medical Health*, *20*(2), 133-154.

Kimerling, R., Street, A., Pavao, J., Smith, M., Cronkite, R. C., Holmes, T. H., & Frayne, S. (2010). Military-related sexual trauma among Veterans Health Administration patients returning from Afghanistan and Iraq. *American Journal of Public Health, 100,* 1409-1412. doi:10.2105/AJPH.2009.171793

Klein, R., & Phillips, S. B. (2008*). Public mental health service delivery protocols: Group interventions for disaster preparedness and response*. New York: American Group Psychotherapy Association.

Klein, R. H., & Schermer, V. L. (2000). *Group psychotherapy for psychological trauma.* New York: Guilford.

Lubin, H., & Johnson, D. R. (2008). *Trauma-centered group psychotherapy for women: A clinician's manual.* New York: Haworth.

Mendelsohn, M., Herman, J., Schatzow, E., Kallivayalil, D., Levitan, J., & Coco, M. (2011). *The trauma recovery group: A guide for practitioners.* New York: Guilford.

Miller, A. (2014). Threat assessment in action. *Monitor on Psychology*, *45*(2), 37-42.

O'Brien, T. (2009). *The things they carried*. New York: Mariner.

Paymar, M. (2000). *Violent no more: Helping men end domestic abuse*. Alameda, CA: Hunter House.

Phillips, S. (2012a). Military mothers: Reflections of trauma and triumph. *Psych Central*. Retrieved February 10, 2014, from http://blogs.psychcentral.com/healing-together/2012/05/military-mothers-reflections-of-trauma-and-triumph/

Phillips, S. (2012b). Finding the way home from war: A promise and a process. *Psych Central*. Retrieved February 10, 2014, from http://

blogs.psychcentral.com/healing-together/2012/11/finding-the-way-home-from-war-a-promise-and-a-process/

Phillips, S. (2013). Parents of our military: Supporting their care and courage. *Psych Central*. Retrieved February 10, 2014, from http://blogs.psychcentral.com/healing-together/2013/11/parents-of-our-military-supporting-their-care-and-courage/

Phillips, S. (2014). No innocent bystanders: The role we play in reducing violence. *Psych Central*. Retrieved February 10, 2014, from http://blogs.psychcentral.com/healing-together/2014/01/no-innocent-bystandersthe-role-we-play-in-reducing-violence/

Phillips, S., & Kane, D. (2008). *Healing together: A couple's guide to coping with trauma and post-traumatic stress.* Oakdale, CA: New Harbinger.

Raine, N. V. (1999). *After silence: Rape and my journey back.* New York: Three River Press.

Schwab, G. (2010). *Haunting legacies: Violent histories and transgenerational trauma.* New York: Columbia University Press.

Shengold, L. (1989). *Soul murder: The effects of childhood abuse and deprivation*. New Haven, CT: Yale University Press.

Shneidman, E. S. (1972). Foreword. In A. C. Cain (Ed.), *Survivors of suicide* (pp. ix–xi). Springfield, IL: Charles C. Thomas.

Stolorow, R. (2007). *Trauma and human existence: Autobiographical, psychoanalytic, and philosophical reflections.* New York: Analytic Press.

Taft, C. T., Monson, C. M., Hebenstreit, C. L., King, D. W., & King, L. A. (2009). Examining the correlates of agression among male and female Vietnam veterans. *Violence and Victims, 24*, 639-652.

Underwood, M. M. (2008). Children and families dealing with a traumatic event. In R. H. Klein & S. B. Phillips (Eds.), *Public mental health service delivery protocols: Group interventions for disaster preparedness and response* (pp. 1-21). New York: American Group Psychotherapy Association.

United States Department of Justice, Office of Justice Programs. (2004). *Veterans in state and federal prison*. Retrieved from http://www.ojp.usdoj.gov/bjs/abstract/vsfp94.htm

van der Merwe, C. N.-M., & Gobodo-Madikizela, P. (2008). *Narrating our healing: Perspectives on working through trauma.* Newcastle, UK: Cambridge Scholars Publishing.

Vossekuil, B., Fein, R. A., Reddy, M., Borum, R., & Modzeleski, W. (2002). The final report and findings of the Safe School Initiative: Implications for the prevention of school attacks in the United States. Washington, DC: United States Secret Service & United States Department of Education. Retrieved from http://www.secretservice.gov/ntac/ssi_final_report.pdf

Weiner, J., Richmond, T. S., Conigliaro, J., & Wiebe, D. J. (2011). Military veteran mortality following a survived suicide attempt. *BMC Public Health, 11,* 374. doi:10.1186/1471-2458-11-374

World Health Organization. (2003). World report on violence and health. Retrieved from http://www.who.int/violence_injury_prevention/violence/world_report/en/

World Health Organization. (2008). The global burden of disease. Retrieved from http://www.who.int/topics/global_global_burden_of_disease/en

Ziering A., & Barklow, T. K. (Producers), Kirby, D., (Writer/Director). (2012). *The invisible war* [Motion picture]. New York: Cinedigm.

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