

Forced Silence: A Neglected Dimension of Trauma

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The author describes one specific facet of the psychological trauma attendant upon physical violence—the implications of the victim's forced silence about the event. This prohibition of communication, enforced by some implicit or explicit threat, constitutes a secondary trauma of enormous import and has been ignored in the literature. Exploration of this concept can sensitize therapists and point the way toward empathetic and effective intervention. (Am J Psychiatry 139:872-876, 1982)

Psychiatry as a profession is confronted constantly with one manifestation or another of man's propensity for violence. Today Freud's theory of libido and the contributions of ethnology (1, 2) and psychology (3) constitute the cornerstones of our understanding.

In the last two decades, clinical inquiry in three important areas has pointed to the importance of attending not only to the inner meanings of violence but to actual traumatic events as well. This work has come from the fields of child abuse (4), rape (5, 6), and "war neurosis" (7-9).

I am interested in focusing on a particular concomitant to many episodes of trauma—the command that the victim remain silent about the episode. When one is physically vulnerable, fearing further violence or death, this forced silence necessarily shapes subsequent reaction to the trauma. It constitutes a secondary trauma of enormous importance. What happens, for instance, if the initial trauma takes place at an age when character structure is only beginning to congeal? It has been recognized for some time that physically abused children often find themselves, later in life, the objects of further violence.

In describing "moral masochism" as a "bid for the affection of a hating love object," Berliner (10, p. 41) made clear that parental hostility is crucial to the

development of a masochistic stance. Kohut expanded on this point from a different theoretical perspective (11, p. 27). For those hurt in adulthood it is necessary to appreciate the vastly complex interrelationships among preexisting personality variables, the antecedents of the traumatic event, and the nature of the trauma.

I am presenting the following case histories to focus attention not only on the power and consequences of trauma but also on the labyrinthine ways in which these issues surface. The unfolding of each patient's secret is a nodal point in therapy, underlining the power of forced silence.

CASE REPORTS

Case 1. Ms. A, a 19-year-old nursing assistant, came to therapy with complaints of depression, self-destructive tendencies, and a desire to "get her life together." Her symptoms included depression, difficulty forming and sustaining relationships, and occasional feelings of derealization, depersonalization, and confusion in her thinking.

Ms. A described her parents' relationship as "horrible"; they abused alcohol, alternately snubbed and bickered with her, and treated each other with disdain. The youngest of five siblings, Ms. A remembered feeling ignored and unwanted since childhood. Her parents set few limits on her behavior and, when they did intervene, were inconsistent and punitive.

For 3 years before beginning treatment Ms. A had been cutting her arms. This happened when she felt tense or bad—as though she felt she deserved punishment—and when she was particularly angry at her parents. Her lacerations were hidden by clothing, never resulted in hospitalization, and were never commented on by her parents. At one time of particular stress, 6 months after beginning treatment, Ms. A burned her face and was hospitalized for a week. Her therapist confronted her parents with the seriousness of this act. Ms. A later acknowledged that this message finally got their attention. They watched her closely for a week but then appeared to forget the episode.

During her first year in therapy Ms. A was able to move away from home and reported improvements at work and with friends. Her dysphoria continued, although at times she was able to acknowledge and even enjoy her beginning successes. Adjunctive antidepressant therapy proved to be of modest but substantive benefit.

At one point early in the second year of therapy she mentioned her dread of an impending physical examination. When this issue was pursued she became reticent and unusually anxious. I asked if she had ever been hurt,

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physically, by another person. Ms. A looked startled and answered in the affirmative. When I suggested to her that it might be important to share her memories of these experiences, she agreed but had enormous difficulty proceeding. She explained her reluctance in terms of a fear of rejection, a desire not to face the pain of her memories, a feeling that she would be disappointed in my reply. However, she also seemed to have a real desire to talk about what had happened. The only other time she had explicitly mentioned any of these traumatic events had been with a therapist she had seen while she was in high school. Ms. A had, in one session, alluded to having been beaten up while she was on a date. Her therapist failed to pursue the issue, and Ms. A terminated therapy within the next month.

To open this area of history in the context of Ms. A's consistent distress and ambivalence about exploring the matter took a great deal of patience and persistence, but after some time the following content emerged: when she was about age 7, despite her mother's warning not to go into the neighbors' house alone, Ms. A did so. The man who lived there was alone and had invited her in. He forced her to remove her clothes, fondled her, and threatened to harm her if she ever told anyone what had happened. She was forced to repeat this episode with him once and was similarly threatened at that time. She never dared say anything about these two encounters.

Then, on four separate occasions in high school, she had been beaten up by boys whom she dated. On one of these occasions she was raped. She never mentioned any of these events but, when physically bruised, had hoped for some notice, some response from her parents. There was none.

Since then she had been frightened of men and uncomfortable with her own sexuality. She feared that being intimate would in some nebulous but unavoidable way lead to physical injury. Only after talking, bit by bit, about having been threatened and having been silent, was she able to explore the violent events of her past and their continued impact. From this time forward, her capacity to tolerate affect and to allow herself trust, sexuality, and autonomy increased as never before.

Case 2. Ms. B was a 25-year-old married mother of two children when she began twice-weekly psychotherapy. She had been referred for depression and suicidal ideation. One week before therapy began, a friend had committed suicide. He had apparently been quite troubled, but Ms. B felt directly responsible for his suicide.

She was intelligent and talented in areas as diverse as athletics, music, and language. Raised in an upper-class family, she had been "shown off" since her earliest years. However, beginning in adolescence she had been telling elaborate and fabricated stories and was caught only rarely. After completing college she met and married her husband, then moved away from her parents' home.

Ms. B's father worked in the upper echelons of corporate administration. Her mother, whom she described as a controlling woman with serious psychosomatic symptoms, was active in public life. Ms. B had one older brother, who was born with a congenital deformity.

The first 6-8 months of therapy successfully addressed issues of loss, guilt, and responsibility. However, on several occasions, without apparent warning, she disappeared from home, to return after having been physically injured by men

whom she met. Although Ms. B was vague and reluctant to discuss these events, it emerged that since her early teens she had been going out with older men, often being physically or sexually abused by them. Her parents did nothing to structure her involvement with men and never commented on marks of physical violence. Ms. B reported feeling that "this is what people do" and that her pain was in some way deserved.

These episodes gradually became less frequent, and Ms. B's relationship with her mother came more into focus. It emerged that her mother had been both jealous and hostile toward her since her earliest years and that her mother's behavior was never questioned or controlled by her father. This history came slowly and felt "treasonous" to Ms. B but seemed to gradually free her to like herself, make friends, and pride herself on a different relationship with her own children.

Increasingly, as the second year of therapy ended, Ms. B felt that she did indeed deserve a life free of violence and suffering. When, after 10 months devoid of self-destructive behavior, she once again—in response to vague panicky feelings—"arranged" to be beaten by strange men, therapy was obliged to delve deeper. In this context and to understand more explicitly what would happen at times when she was hurt, I urged her to share details in therapy. She resisted, fearing that if she began to talk about what had happened she would lose control. She talked about how she had "always" shut from consciousness as much as she could of the feeling of pain, waiting for the episode to end, then forgetting in order to go on.

Responding to her use of the word "always," I asked how early there had been events to require such an extreme form of self-protection. She winced with this question as though she had been struck. For several weeks we talked about and around the terror that she felt, the content of which she would not share. At one point I asked her whether threats had ever accompanied the as yet undescribed trauma and if that was what kept her from speaking. She acknowledged that she had repeatedly been threatened with death and that she could still feel the power and presence of that threat.

Only after we talked at length about the threat did she begin to fully realize that she was no longer vulnerable, that it might be safe to talk. Gradually she related a history of physical abuse by her mother beginning before she was 4 years old. She had been teased, burned with a lighter, beaten, and cut with kitchen knives. This would happen at home while her father was at work and was always accompanied by the threat that any report to her father would result in death. Ms. B could remember hiding from her mother but never successfully. As this history emerged, Ms. B required hospitalization to establish some feeling of safety and containment. Only after finally revealing the details of these punishments, so long kept locked away, could she begin to deal with them as events of the past.

DISCUSSION

For these patients, the consequences of having been traumatized cannot be described, let alone understood, outside the context of their prolonged silence after the event. In silence, the pain and subliminal memories of pain festered. Neither working through

an abandoning parent who fails to notice them. Often the clue involves a literal repetition, as in both the cases I have presented. These repetitions must be understood as unconscious attempts to dramatize what cannot be spoken or even to master what was initially overwhelming, and not purely as manifestations of masochism.

It is crucial to understand why these patients often have so much difficulty unburdening themselves in a direct and spontaneous way. The first reason is the feelings of shame or guilt so common among the victims of trauma (4-6). "It is as if the only way to make some sense of an otherwise meaningless, horrifying assault is to cast it in terms of shame and guilt" (unpublished manuscript by Russell). Second is the defense of magical thinking ("If I don't speak of it, perhaps it never was"). Third is the fear that the therapist's response may prove disappointing and compound the sense of abuse. Fourth is a fear that the therapist will frankly reject the patient or will question the content of the patient's report in such a way that the patient must either leave the therapist or abandon his or her own notion of what really happened. If the transference is idealizing or dependent, the patient may sense such revelations as an enormous risk.

There is another major difference in the process of abreaction when trauma has been complicated by threat: the affect experienced when a patient finally speaks. In every case, as these memories are shared for the first time, patients experience genuine terror. It is as though that same feeling of vulnerability—intact and alive from the time of original trauma—is reexperienced. In none of the cases with which I am familiar could this terror be understood solely as a dyadic transference phenomenon. The terror is as though patient and therapist convene in the presence of yet another person. This third image is the victimizer, who long ago demanded silence and whose command is now being broken. The numbing intensity of these occasions, when patients feel as though they are risking their lives to tell their stories, suggests that as long as there has been any desire to unburden, confess, or heal, there has also been the shadow of this third person. Psychologically, the relationship with this person has continued since the time of the threat.

In therapy these victims needed to be helped to understand why they had been silent, that it was in fact no cause for shame. This educative function of therapy served to help each patient forgive herself and move on. However, in the final analysis, the spell of the threat was broken only by defiance.

Telling one's story allows an understanding of the impact of the threat. This process taps the strength of a different relationship, the therapeutic one. It begins with abreaction and moves through understanding and reworking to finally allow the internalized image of the victimizer to be put aside. As a result, psychological freedom becomes more possible.

In both of these cases a period of productive therapy proved to be only a beginning. With growing trust and continued exploration, "clues" were finally read in a way that catalyzed the unfolding of hidden lines of inquiry. Certainly, success did not hinge on perfect responses to single bits of information. However, therapists can be expected to respond to patterns of such clues over time and can also be expected to avoid those responses which predictably curtail further communication. These responses are technical errors or countertransference phenomena and include 1) a focus on intrapsychic processes at the expense of attention to external realities, 2) subtle insinuations that "if something happened, perhaps you set it up," 3) frankly overlooking material that relates to violence, threats, or fear of violence, and 4) refusal to entertain the possibility that what we are being told may literally have happened. The frequency of these and similar phenomena reflect how painful it can be for us to confront and empathetically experience the extremities of man's capacity for sadism or helpless suffering.

In each of the cases I have presented, therapy was irrevocably changed once threat and trauma had been shared. We moved more powerfully, and with less resistance, toward resolution. Although previously these two women had progressed and matured in many spheres, in a sense they had been "frozen" with the notion that their traumatic relationships—kept alive by the bond of silence—were in some ways normal. More often than we would like to think, threats accompany trauma and are taken at face value by victims. In these circumstances years can pass before the initial trauma is ever mentioned. And even then, communications can be veiled or indirect. To understand these cases and to apply what we have learned about trauma in general, we must realize the power of the threat and the tenacity of the victim's psychological relationship with the victimizer. With these issues in focus our capacity to respond astutely, empathetically, and effectively becomes vastly enhanced.

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Assessment of Reliability in Multicenter Collaborative Research with a Videotape Approach

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The authors, as part of the ongoing NIMH Collaborative Study on the Psychobiology of Depression, used an analysis of variance design and videotaped interviews to explore the effects of sources of variance on the reliability of the measures being used by the NIMH study. In spite of substantial differences among interviewers in background or orientation, the authors found that diagnoses and symptom ratings were made with a high level of reliability. These results suggest that the use of structured interviews and diagnostic criteria, when combined with a careful and systematic training program, can lead to good levels of diagnostic reliability. (Am J Psychiatry 139:876-882, 1982)

Research within a single center using a number of interviewers can, by itself, produce serious problems in reliability. In multicenter collaborative research, conducted at a national or international level, these problems tend to be compounded, and reliability becomes an increasingly complex issue requiring systematic and sophisticated methods of assessment. The National Institute of Mental Health (NIMH) Collaborative Study on the Psychobiology of Depression (1), an ongoing multifaceted study of affective disorders involving five different centers and a large number of interviewers from various types of training backgrounds, has employed a methodology for studying

and dealing with at least some of these problems in reliability. This paper describes one method employed to study reliability, the examination of intercenter and interrater reliability through the exchange of videotaped interviews.

SOURCES OF VARIANCE AFFECTING RELIABILITY

Traditional psychometric theory has identified several sources of variance that may affect the reliability of ratings (2). The term "subject variance" refers to variability within subjects, and "occasion variance" refers to variability as a result of sampling at different times. For example, in a test-retest design, the patient's condition or perception of his condition may change markedly if the testing intervals are separated by a large time period. In most reliability studies, subject and occasion variances represent valid measurement variance. Depending on the design of the study, these variances may place a ceiling on the levels of reliability that can be estimated. In other types of studies they are themselves the variables that are being investigated, as in follow-up studies.

On the other hand, three additional sources of variance have been noted that tend to impair research investigations but can be controlled or corrected through careful planning. "Observation variance" occurs when observers have a different perception of the same phenomenon. For example, one clinician may interview a patient and interpret mildly disorganized speech as representing formal thought disorder, while another clinician may consider it within normal limits. "Information variance" occurs when interviewers develop a different information base because they have

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