COMBAT AND HUMAN EXISTENCE:  
Toward an Intersubjective Approach to Combat-Related PTSD

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The author proposes a short-term, intersubjective model for treating combat-related post-traumatic stress disorder (PTSD). Psychodynamic approaches to adult-onset PTSD lack the evidence and popularity of other approaches because adult-onset traumas are fundamentally distinct from the developmental, or childhood-based, traumas that psychoanalysis evolved to treat. An approach based in intersubjective systems theory can address this problem. The writings of Robert Stolorow (2007) in Trauma and Human Existence, which the author first read while deployed to Iraq as a psychiatrist, fundamentally changed his understanding of trauma and its treatment. The author gives an overview of Stolorow’s ideas about trauma, and then describes his six-phase short-term intersubjective treatment approach. Extensive case material from a treatment that occurred in Iraq illustrates each of these phases. The author then compares his and Stolorow’s views to those of other contemporary relational psychoanalytic writers. Future directions include the manualization and empirical testing of this approach in order to determine its replicability, its utility for therapists who lack extensive psychoanalytic training, and its generalizability to populations with adult-onset trauma outside the military.

Keywords: combat, PTSD, short-term psychodynamic therapy, intersubjectivity, adult-onset trauma

I did not plan on developing a short-term therapy. It was born of necessity. I would prefer to treat soldiers and Marines in a calm office with minimal external constraints on the frame, but that has rarely been possible for me. A combat zone is no place for the
intense, prolonged work of psychoanalysis. Even back in the safety of their home bases in America, military personnel seeking treatment and their active duty military therapists are members of a transient population. Whenever therapy begins, frequently either the patient or therapist will move within a year or less. I’ve treated service members suffering from post-traumatic stress disorder (PTSD) on locked psychiatric units, at their bedside on trauma surgery floors, and at a former Iraqi airfield with my 9 mm pistol and body armor on the floor beside me. In all of these circumstances, either the patient or I was always in the process of going somewhere else. Time has rarely been on our sides. Fix it and move on becomes the mentality. Even before experiencing combat and its subsequent effects, most military personnel do not have the time or motivation for extended exploratory work. Once in therapy, they often drop out because of various internal or external pressures, ranging from legitimate mission requirements to stigma. Dr. Hoge and his colleagues have studied stigma in soldiers and Marines deployed to Iraq and Afghanistan, clearly showing that it is a barrier to care (Hoge et al., 2004). Within this context of war, transient relationships, and stigma toward mental health care, I have struggled to find a psychodynamic understanding of PTSD that might help me reach traumatized military personnel. I feel that most of the psychoanalytic descriptions of trauma describe only the effects of childhood, or developmental trauma, and do not address the effects of traumatic experiences for an adult with a relatively benign developmental history. I eventually found intersubjective systems theory, which has felt liberating to me.

In this article, I present one of my initial attempts to treat combat-related PTSD, a form of adult-onset trauma, with short-term therapy from an intersubjective perspective. The therapy occurred with a soldier I’ll call Mr. A while both of us were deployed to Iraq. I felt an urgent need to try a new form of therapy with him after he failed to respond to standard cognitive therapy while back in America. I would have preferred to get to know Mr. A in long-term therapy, but that approach was not possible given the circumstances. My intention is that this account will contribute to the advancement of contemporary psychoanalytic ideas in several ways. It is the only description, to my knowledge, of the treatment of military personnel with adult-onset trauma from an intersubjective perspective. It supports Boulanger and others’ views (Boulanger, 2007) that adult-onset trauma must be understood differently from the traditional psychoanalytic conceptualizations of childhood traumatic experiences. It is one of the initial steps toward proposing a short-term intersubjective treatment model for empirical research. Finally, it indicates the need for further research both to hone this approach and to determine whether it might have utility with populations outside the military who have adult-onset trauma and also cannot engage in open-ended, exploratory work.

The Need for an Intersubjective Approach

In spite of the multiple ways described for treating PTSD in the vast empirically based trauma literature, consensus on a definitive treatment remains elusive. And yet, psychodynamic therapies struggle to compete with other models for recognition of their efficacy. Forms of cognitive–behavioral therapy (CBT) currently have the most evidence for efficacy [Veterans Affairs/Department of Defense (VA/DoD), 2010]. However, therapies with the most empirical support also have dropout rates as high as 54% and nonresponse rates as high as 50% in some studies (Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). While psychodynamic approaches appear as a group to lag behind others, such as CBT, in development and acceptance among therapists for disorders such as PTSD (Foa,
Keene, Friedman, & Cohen, 2008), other writers have argued that there might also have been a certain degree of denial about the evidence for the efficacy of psychodynamic therapy for many disorders (Shedler, 2010). Regardless of the reason of this possible lag, psychodynamic therapy has entered into the empirically driven research discourse in recent years, with empirical research on short-term psychodynamic models (Levy & Ablon, 2009) and manualization of psychodynamic approaches to panic disorder (Mikulincer et al., 2007) and borderline personality disorder (Bateman & Fonagy, 2006; Clarkin, Kernberg, & Yeomans, 1999).

But besides any arguments about the utility of randomized controlled trials, I think there is a more fundamental reason why psychoanalytic therapy has not kept up with other forms of therapy for adult-onset PTSD. As a whole, psychoanalytic theory is not applicable to adult-onset trauma. As I describe further on, psychoanalysis’s traditional developmental models might not be relevant to an adult-onset trauma that disrupts someone’s life after a relatively safe and supportive childhood. With their foci on developmental causes for adult problems, most psychoanalytic approaches, particularly intrapsychic ones, are not intended to formulate a problem as starting in adulthood. They can thus be perceived as blaming an adult’s reaction to an event in their adulthood on relatively benign childhood events and emotional experiences.

I have struggled to develop my psychodynamic understanding of combat-related PTSD over the past decade or so. My understanding started in a traditional, American ego psychology perspective. Regardless of the therapeutic approach, I have come to realize that soldiers and Marines with PTSD can be difficult to engage in treatment. Frequently, they do not want treatment, or they avoid it out of fear for their careers or out of shame. Almost universally, they do not feel understood. I have found that Robert Stolorow (2007) describes this phenomenon well: a traumatic emotional experience can alienate those he calls the traumatized from the “normals.” In milder forms, the patient might refuse to talk about the trauma, or say to the provider, “You just can’t understand.” As I have seen, people who have been traumatized don’t always simply assume the sick role and formulation in which we would like to put them. Instead of seeing traumatic soldiers or Marines as having dysfunctional automatic thoughts, a shattered self, or a regressed ego, I was beginning to feel that their experience of the world and themselves had been shattered. They frequently did not seem to be in the same world as the rest of us, or at least me. I was recognizing the need for an approach that addresses shame and fosters a human relationship between patient and therapist, instead of fostering a distance based on alleged objectivity. I was realizing that a developmental-based, one-person approach was probably leaving patients frustrated and might have been reinforcing a sense of disconnection, but I was struggling to find an alternative. I was moving well beyond my roots in one-person psychologies but was not sure where my experiences were leading me.

As I left for a deployment to Iraq in the summer of 2008, I was wrestling with how to reach soldiers with traumatized experiences that left them with profound shame and difficulties in their relationships with others. I took a Psychoanalytic Electronic Publishing (PEP), Archive 1, Version 7, DVD with me and spent much of my spare time in Iraq reading the psychoanalytic literature, looking for perspectives that might help me to understand my patients better. A few months into the deployment, I developed an even stronger sense of urgency as one of my patients killed himself. I felt the effects of his suicide on his unit, the medical staff who tried to resuscitate him, and the other mental health team on base (Carr, 2011). That soldier, too, had an exquisite sense of shame and isolation. As I thought of him and continued to meet with my other patients there in Iraq, I felt a strong urgency to find a better way to understand the effects of trauma. I then
stumbled upon the writings of Robert Stolorow. I obtained a copy of his recent book, *Trauma and Human Existence* (2007). It fundamentally changed how I work with traumatized military personnel. I no longer looked for intrapsychic deficits to understand the traumatized person’s reaction to a recent trauma. Instead, I began to focus on the patient’s subjective experience of the recent trauma itself. Stolorow verbalized what I had intuitively known, that an event that happens in adulthood can in and of itself shatter one’s world experience and also cause tremendous shame. Stolorow’s ideas also fundamentally shifted my approach to patients with two concepts: empathic introspection and the contextualization of affect. I no longer looked for drives, conflicts between structures, self deficits, or defenses. I understood affect as being determined between people, or the surround. Understanding the emotional context became much more important than focusing on an intrapsychic formulation of the patient’s mind. Stolorow’s ideas profoundly altered my understanding of trauma on an individual’s subjective experience of the world and helped me be empathic with traumatized soldiers in ways that enabled us to connect. My approach to patients was shifted irrevocably away from a one-person perspective. With these changes, my work with them became much more meaningful and useful to both of us. I will never forget the first soldier who said to me, “Doc, you get this more than anyone I’ve talked to about it.” In my remaining months in Iraq, I read Stolorow’s book *Trauma and Human Existence* repeatedly, carrying it with me as I traveled between forward operating bases and outposts. I applied his ideas in my treatment of several soldiers in Iraq suffering from PTSD.

After I returned home in early 2009, I began to formulate a short-term intersubjective treatment for combat-related PTSD. It utilizes a phenomenological-contextualist, empathic approach to understand adult-onset trauma. Although intersubjective systems theory takes into account developmental history in other treatment contexts, it is not necessary in order for this approach to work for an adult-onset problem. Incorporating an intersubjective approach into a short-term model can overcome the time limits and other barriers to long-term treatment that are often inherent to a military setting.

**Intersubjective Systems Theory and Trauma**

Before describing my short-term intersubjective work with Mr. A, I want to provide a brief overview of Stolorow’s understanding of traumatic emotional experiences. Those aspects of it, or intersubjective attitudes, central to a treatment approach for combat-related PTSD include (1) the primacy of affect, (2) the radical contextualization of emotional life, (3) striving to understand the patient’s experience and organizing principles through empathic introspection, and (4) the conceptualization of trauma as unbearable affect.1

In his book *Trauma and Human Existence*, Stolorow (2007) applies intersubjective systems theory’s phenomenological-contextualist approach to trauma. He tries to under-

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1 At the time I treated this soldier, Robert Stolorow’s book *Trauma and Human Existence* (Stolorow, 2007) was my primary source for understanding intersubjective systems theory. Since returning from Iraq, I have been able to study many other works on it, including several other books by Stolorow and his colleagues: *Psychoanalytic Treatment: An Intersubjective Approach* (Stolorow, Brandchaft, & Atwood, 1987), *Context of Being* (Stolorow & Atwood, 1992), *Working Intersubjectively* (Orange, Atwood, & Stolorow, 1997), and *Worlds of Experience* (Stolorow, Atwood, & Orange, 2002).
stand the experience of trauma’s effects on the individual, focusing on affect. His ideas about it include understanding trauma as unbearable affect and its effects as “an excruciating sense of singularity and solitude,” the loss of “absolutisms” of everyday life, the loss of a sense of time (temporality), loss of a sense of being (ontological unconscious), being overcome with facing and witnessing death (authentic being-toward-death) leading into the eventual resoluteness to live again, and loss itself as a relational phenomenon.

In a theory such as intersubjective systems theory, where affect is central to understanding the human mind and our interrelatedness, trauma is understood as unendurable affect. The event itself or the bodily sensations one feels during the traumatic event is not the trauma. As Stolorow (2007) says, “Pain is not pathology” (p. 10). Instead of the event itself, Stolorow focuses on the inability to bear the emotions related to the trauma as the source of pathology. This traumatic emotional experience must be processed with others in order to be integrated into one’s experiential world. Affects, or emotions, occur between people, and disturbing emotional experiences require what Stolorow calls “attunement” from another person or group in order to bear and integrate them. This attunement consists of feeling understood, feeling gotten. A sense of sharing the burden of overwhelming affect with someone else in a “holding context” gives these feelings a place to “live and become integrated.” If no such attunement exists, then the person cannot endure this emotional state and must find maladaptive ways to sooth the state, usually based in dissociation. When the trauma occurs in early childhood, traumatic emotional experiences that are not integrated may remain in a somatic, nonverbalized state. In contrast, in adolescents or adults who have already developed the language necessary to verbalize and integrate emotions into their experiences but cannot integrate a specific traumatic emotional experience, these unintegrated feeling states may be experienced as dissociative or somatized phenomena until they are put into words with another person.

Shame holds an important place in intersubjective theory, especially when dealing with traumatic experiences. Instead of feeling attunement from others, a person dealing with such overwhelming affect might instead experience denial or even rejection from others. This lack of attunement or even hostile rejection can lead to severe shame and an intense “sense of singularity and solitude.” Stolorow has recently listed different aspects of shame in a “shame family” (Stolorow, 2010). Shame linked to an inability to find a relational home for disturbing affects can greatly affect military personnel, who might feel they are expected to show no pain. Stolorow also points out that, while a relational home may help to bear and integrate most trauma, some experiences are simply too extreme for attunement. These, perhaps ones such as emotional responses to combat, inherently create a profound sense of singularity, solitude, and subsequent shame.

Stolorow (2007) describes in phenomenological terms several potential effects of unendurable traumatic emotional experiences. One of these he terms “the loss of absolutisms of everyday life” (p. 15). People speak of their view of the world as being changed forever after a traumatic event that cannot be processed. Stolorow describes this as a “shattering of one’s experiential world.” One might also describe an aspect of this shattering as a loss of healthy denial, or absolutisms. Absolutisms refer to the minor, false beliefs that each of us hold to help us get through our lives with less anxiety, creating the illusion that the world is always predictable and safe. For instance, most people assume that when they go to bed at night that they will wake up in the morning. People also usually believe that when they say goodbye to family members and go to work in the morning, they will see them again when upon returning home in the evening. Of course, we all know that there is a rare, outside chance, that we will die that night in our sleep, or that one of our family members will be murdered or we will die during the day. But for
the most part, we don’t fear such horrible events happening every day. We don’t feel these risks. People who live comfortably in this healthy denial Stolorow calls “the normals.” This is not meant to have a negative connotation. Having these beliefs is healthy and essential in order to live our lives.

According to Stolorow, a person who has experienced traumatic, unendurable affect following a horrible event typically no longer experiences the world in a “normal” way. The person doesn’t simply believe or suspect that the world remains dangerous, but feels its dangerousness. He or she feels, for instance, that in our world, people die in their sleep or that families are murdered. From such a perspective, all other people seem to continue to live their lives, just as the traumatized person did before the trauma. But instead, the illusions of a safe and mundane existence have been shattered for the traumatized person. The “normals” who continue with their routine lives can’t seem to understand what the traumatized person feels forced to recognize: that life is fragile and can end at any time. There seems to be an enormous chasm between the traumatized person’s loss of absolutisms and the “normals’” perspective (p. 14). Such a sense among those who have been traumatized does not denote superiority, as if the sadistic saying “what doesn’t kill you only makes you stronger” were true. People don’t feel stronger with such traumatic experiences. Instead, a perceived loss of safety creates a sense of singularity and isolation, of “alienation and aloneness” (Stolorow, 2007, p. 14).

In addition to absolutisms, Stolorow explores the effects of traumatic experiences on a sense of time. He believes that trauma disrupts a person’s sense of time, what he calls a “loss of temporality.” By this, he means a loss of continuity between past, present, and future. This has also frequently been described in the psychoanalytic literature as dissociative phenomena, and Stolorow defines dissociation as “traumatic temporality” (Stolorow, 2011). For the “normals,” or nontraumatized, a moment in time always contains the person’s past, the present, and perceptions of the future. All three of these dimensions are present and united in any given moment. For those who have experienced emotional trauma, unification of these three dimensions of time is shattered, just like the rest of their experiential worlds. The person may still feel trapped in the moment of emotional trauma, unable to escape that past as it constantly invades and dominates the present. In those moments of frank dissociation, there is no present. Time feeds circularly back to the traumatic event (Stolorow, 2011). Such a sense of the loss of time compounds a sense of alienation from others, and a sense that the “normals” in their safe worlds of experience with coherent pasts, presents, and futures can never understand the separate, dissociated state in which the traumatized person lives.

Next in his writings on the phenomenology of trauma, Stolorow describes what he calls the ontological unconscious. This conceptualization articulates the unconscious effects of trauma. It refers to a loss of one’s sense of being. This loss of one’s sense of existence occurs as a result of a disruption in giving traumatic emotional experiences an expression in language. Stolorow (2007) argues that, developmentally, affects are first experienced for young children as somatic states within the body. These only become coherent, distinct emotions through their expression in language with a caregiver. Stolorow suggests that the epigraph “If I feel, therefore I am” accurately conveys the nature of being, and therefore one’s sense of being is one’s affects (p. 29). Furthermore, all affects are determined within the context of relationships with others, or intersubjectively. Without feeling attunement with others, the traumatized person loses a sense of context and of being-in-the-world. Following trauma, context and a sense of being start to disappear with this loss of attunement because emotions are so contextually determined and emotional attunement with others is so central to our sense of humanness. If a
relational home does not emerge that helps a person to articulate a traumatic experience and therefore bear and integrate it, the unbearable emotional state becomes an unconscious traumatized state, what Stolorow calls an ontological unconscious (Stolorow, 2007, p. 26). An adult who suffers adult-onset trauma may experience this ontological unconscious state as dullness, depression, vague somatic problems, other dissociated states, or a loss of vitality.

Connected with the idea of the loss of absolutisms and a state of ontological unconscious, Stolorow applies Martin Heidegger’s conceptualization of anxiety as described in Being and Time to understand how traumatic experiences can create an existential crisis (Heidegger, 1927/1962). Basically, unendurable traumatic emotions force upon the traumatized person the realization that he or she is alone in bearing inescapable death, and that the time when death will come is unpredictable, or indefinite. Each person knows that he or she is mortal, but had probably never, before that traumatic experience, felt it. Healthy absolutisms had, on a day-to-day basis before that experience, concealed inevitable and unpredictable death. Being faced with this fact about mortality, a state Heidegger called “Being-toward-death,” creates great anxiety and shatters the significance of the everyday details of life. A person in this state of mind can no longer feel the need to participate in the aspects of life that used to seem important: work, maintaining relationships, lifelong goals, and so forth. Stolorow (2007) describes how Heidegger divides this state of Being-toward-death into either authentic or inauthentic forms (pp. 35–41). Authentic Being-toward-death is living in this state with significant anxiety and sense of isolation. Inauthentic Being-toward-death is escaping through dissociative numbing. Either way, the person’s previous experiential world is shattered, never to return. Stolorow (2007) described a hopeful way to move beyond this Being-toward-death state. This movement, he called, along with Heidegger, authentic resoluteness (pp. 41–46). As the traumatic emotional experience finds a relational home and becomes integrated, the person might seize upon the opportunity to learn from the experience. He or she gains insight and focus after processing the traumatic experience. The person might realize what should be important in his or her particular life. These may be societal causes that are taken up, or a re prioritizing of individual goals or relationships.

Whereas Heidegger considered each of us alone in facing our mortality, or finitude, Stolorow (2007) utilizes the ideas of other writers and his own experience to conclude that death is fundamentally relational (pp. 47–51). We all have mortality in common, and come to know death by seeing those around us die. But we do not have to be as alone with death as Being-toward-death portrays. Just as all other emotional life is context dependent, so too, the extent to which we can find a relational home with others to bear and integrate our mortality into our experiential world determines our experience of it, both the mortality of others and our own. As we realize this commonality of our shared mortality, we recognize that we are, what Stolorow and others call, “siblings in the same darkness” (p. 46). We can reach out to each other and strive to understand each other through this common ground, our shared finitude. Stolorow also feels that those who have been traumatized in similar ways are siblings in that particular darkness of trauma as well, whether it is the trauma of losing a loved one, of being raped, or of experiencing combat. In fact, just like death, forms of trauma are ubiquitous. We will all eventually experience some form of it in our lives. Stolorow sees the experience of trauma itself as inescapable as our shared mortality. He feels that the need for twinship experiences is ubiquitous because of the ubiquitous nature of trauma (2007), disagreeing with the Kohutian concept that twinship is an inherent, developmental self-object need (Kohut, 1977). We all want our traumatic experiences to be understood, and so we cling to those who have also experienced similar
trauma. It seems to us that only they can understand our experiences. Twinship is necessary because traumatic emotional experiences are inevitable for us. Our common finitude and traumatic experiences leave all of us desiring an "existential kinship-in-the-same-darkness" (Stolorow, 2007, p. 49).

Phases of Treatment

There is extensive writing about models for short-term psychodynamic therapy. The majority of them are written from a classical ego-psychological viewpoint. A few prominent exceptions, written from more contemporary perspectives, include the relational approach of Safran and Muran (2000), the interpersonal approaches of Strupp and Binder (1984) and Levenson (1995), and also the affect-focused approach of Fosha (2000). None, to my knowledge, has been written from an intersubjective perspective. According to Bloom (1992), there are five generally accepted components of a short-term psychotherapy: "(1) prompt intervention, (2) a relatively high level of therapist activity, (3) establishment of specific but limited goals, (4) the identification of and maintenance of a clear focus, and (5) the setting of a time limit" (pp. 4–5). Each form of short-term therapy, whatever the theoretical orientation, defines these components in different ways. Discussing many of them through the lens of intersubjectivity will help to differentiate the treatment model I am proposing from a more standard longer-term treatment.

I have divided the treatment I am proposing into six phases, although there is much overlap between them. These include (1) Initial consultation and consent to treatment, (2) Addressing shame as the therapy begins, (3) Sessions about the phenomenology of trauma, (4) Seeking an intersubjective key with the patient, (5) Providing an intersubjective home, (6) Terminating and both moving on. Where they are relevant in each phase, I’ll discuss Bloom’s five principles of short-term therapy. I’ll also present sections from the treatment of Mr. A as an example of a short-term intersubjective treatment.

Phase 1: Initial Consultation and Consent to Treatment

The initial consultation within a military setting can often require prompt action on the part of the therapist. It might be shame the patient feels that can end therapy or might be an administrative issue outside the consulting room, such as the patient’s duty status or upcoming deployment. Throughout the course of the therapy, the therapist must remain proactive, anticipating “bumps in the road” and helping to resolve them. With a short-term approach, the therapist must frequently also be willing to direct the topics for discussion in sessions from the beginning, sometimes finding ways that are acceptable to the patient to redirect the discussion back to the agreed-upon topics and goals. Unfortunately, there is not enough time to use the first several weeks or months of sessions to get to know the patient. A therapist seeking to engage patients in any short-term therapy modality must also be willing to engage in proactively educating the patient on the process and working with a sense of urgency. Approaches to therapy aligned traditionally with psychoanalysis, such as allowing the patient to discover the therapeutic process through the analysis itself, hinder the faster-paced work in short term therapy. These concerns make short term therapies more challenging for many therapists who prefer a more passive stance with patients (Bloom, 1992).

Because of the short-term nature of the work, there must not only be a quick assessment period but also screening for exclusionary criteria. The initial consultation will need to seek answers to several basic questions: Is the patient suicidal? What is the
diagnosis, and if related to trauma, what is the source? Are there any comorbidities, including substance abuse, that could impede the treatment? Is there a presence of developmental trauma in addition to adult-onset trauma? Is there evidence a traumatic brain injury might have occurred during the trauma? Is the patient motivated for therapy? If any complicating issues are found with this screening, then a longer course of therapy is almost always indicated. This approach prevents eventual disappointment in a shortened form of therapy when a longer course of treatment was warranted. However, in my experience, the patient’s motivation is a very important factor and can outweigh many contraindications to short-term work. Motivation may also change as the initial session continues and even as therapy sessions ensue, as the patient determines whether or not the therapist can help bear the shame and feelings from the traumatic experience. Also the amount of time the patient can commit to therapy, both each week and longitudinally, is important. If the patient can commit to more than four to six months of therapy, then there is less pressure to pursue a short-term approach.

In addition to being an information-gathering session, the first meeting also involves treatment. The therapist should begin the therapy with an attitude grounded in empathic introspection and fallibilism (Orange, 2006). In terms of fallibility, the therapist must be humble about the limitations of his or her knowledge about trauma, typically based on readings, training, the treatment of other traumatized patients, and on his or her own traumatic experiences. Recognizing these limits will prevent a conjunction, in which the therapist feels that he or she already knows about the patient’s experience and fails to adequately explore the patient’s unique subjectivity. The therapist must be willing to learn from the patient, because, in a phenomenological-contextualist approach, each person’s experience of trauma is unique. The therapist must also be willing to risk change occurring to his or her own understanding of trauma in the dialogue with the patient through empathic introspection. The therapist’s experience cannot be set aside to somehow enter only into the patient’s experience. The patient’s account of trauma will inevitably resonate with whatever traumatic experiences the therapist has had. Trauma is ubiquitous. We have all had traumatic emotional experiences. Military patients with traumatic experiences may be searching for a sibling in the same darkness in relationships with their therapists. If the therapist has not been in combat, personal experience with some other form of trauma can serve as a starting point for an empathic understanding of the patient’s experience. I think that empathic introspection, recognizing and holding in memory one’s own experience with trauma, with each patient helps reduce an initial disjunction if the patient feels that the therapist has minimal or no combat experience. Regardless of the source of trauma, conveying early in the therapeutic relationship that the therapist understands some about trauma, perhaps through disclosing that there has been trauma in his or her past or indicating verbally some familiarity with traumatic emotional states, can help create a sense in the patient that perhaps the therapist will understand. But any such disclosure must be done with an attitude of humility, as each person’s experience of trauma is different. The therapist will also need to emphasize that he or she will be there with the patient, both in the room as another human being helping the patient bear emotional experiences, but also advocating for them within the military chain of command as needed.

Much of the last minutes of the first session and the start of the second session are spent discussing the schedule details of the proposed therapy, including its length. The treatment can last anywhere from 10 to 20 weeks, depending on the available time for both patient and therapist and the patient’s response to it. This time frame can be extended if time permits and if necessary for the work. The time length should only become
open-ended if both patient and therapist agree that the initial goals have been met and the patient wants to address broader issues. As far as meeting frequency, I prefer twice-per-week sessions for this short-term model. Once weekly is too infrequent, I feel, for both participants to stay engaged in this form of work. Frequently, military members cannot come three or four times per week, limiting the opportunity to engage in a more frequent number of sessions. Most military members will have little control of their schedules, particularly if they are enlisted personnel. So I remain as flexible as I can when scheduling appointments for them, and if the patient wants to come but doesn’t feel the chain of command will allow the time away from work, I discuss their fears with them and try to help them find ways to ask for the time. Most service members fear the shame of being away from work and the negative attention they feel it will bring.

After the patient consents to treatment, I start an education process about an intersubjective understanding of affect and trauma in greater detail. I find this helps the patient know what to expect from the therapy, because most military members have probably never been in therapy before or might have been in a different form of therapy in the past. This leads naturally into a discussion of treatment goals, which the patient and I determine based on their desires and my understanding of both trauma and their particular traumatized state. Because this is short-term therapy, the goals need to be mutually agreed upon, circumscribed, and attainable in the allotted time. I help the patient determine the goals with a more active voice in them than I would have in psychoanalysis or long-term therapy. I tell them that the major goal I hold is that they form an emotional bond with me in which their traumatic experiences can start to be borne, processed, and integrated. I explain what those mean. I then add that two potential consequences of such processing of their traumatic experiences in our work together are less of a need for dissociative numbing, and an increased ability to form relationships with “normals” again. If a patient cannot agree on goals that I feel are reasonable for short-term therapy, I may tell them that the therapy length will need to be extended if possible, or I tell them that I feel the goals can only be partially met in the time allotted. A partial completion of the patient’s overall hopes for improvement is typical in short-term therapy. Like other short-term psychodynamic approaches (Horowitz et al., 1984; Sifneos, 1981), this treatment is expected at best to start a process toward improvement, which in this treatment means the integration of emotional trauma, that will continue for the months to years after it is completed.

Mr. A in Iraq

The treatment I offer as an example was with a young soldier I met in Iraq. Some of the circumstances that typically limit treatment duration in the military were present. Mr. A came to my office about half way through my tour in Iraq, when I had a little more than three months remaining there. He was also returning home briefly for R&R a few months later after my departure. As I’ll describe, he, like many soldiers, felt exquisite shame about his traumatic emotional state and thus feared starting therapy. His concerns specifically manifested as a fear of being charged with war crimes. He faced some stigma within his unit, but unlike many soldiers he did not overtly care. He had never wanted to be back in Iraq or remain in the Army and was minimally invested in any perceived risk that seeking mental health care might have on his career or duty status. Like many patients who come to see us, his suffering outweighed any fears or perceived barriers.

Mr. A came to the Combat Stress Control clinic where I was working wanting relief from his feelings about events from a previous deployment. He came in ready to confess,
but at first he spoke in only general terms about his combat exposure. During our initial consultation, he was reluctant to disclose any specific facts. But he did describe feelings that included a sense of being detached from others and of being in a haze. Upon return from his first deployment, he reported drinking heavily to sleep and to reduce his anger. He had been on active duty, but became a reservist after his first deployment to complete the remaining part of his service obligation, and sought care at a Veterans’ Administration Hospital. There he was started on paroxetine and saw a therapist for cognitive therapy over the course of a year. He felt that his treatment there went nowhere. During that time, Mr. A had tried to work and date, but he felt little motivation. He did get married, but at times felt he had little connection with his wife. He felt that she could never understand his experiences and refused to tell her much about them. He had hoped to be out of the Army reserves completely but was ordered to return to Iraq before his commitment ended. When I asked about his combat experiences, he asked several times if what we discussed could be used against him legally. I reassured him that unless he voiced suicidal or homicidal plans, what we discussed would remain confidential. He appeared reassured enough and agreed to continue. We then decided on a treatment plan. We realized that we would only have a few months together to work. Accepting this limit, we agreed to therapy focused on his traumatic experiences during his last deployment to Iraq and agreed to meet twice each week. As part of the prompt intervention and high level of therapist activity of a short-term approach, I described to Mr. A the nature of trauma from an intersubjective perspective. From a discussion of these ideas, we agreed for him to start a process of reconnection with others that would first begin with me and would continue outside the therapy over time. He also asked to continue his long-standing prescription of paroxetine (or Paxil), which I refilled.

Phase 2: Addressing Shame as the Therapy Begins

Shame frequently prevents service members from engaging in treatment. Addressing shame adequately is one of the most important factors of successfully using this treatment model. The therapist must be mindful of it from the initial consultation through the last appointment. The work of processing the emotional trauma cannot begin before the therapist and patient address it. Bearing the shame together might consist of acknowledging it, helping the patient bring the shame to words, or normalizing the experience of shame given the circumstances. Verbalizing with the patient the organizing principle causing the shame is important, such as “I am not a man if I cannot tolerate combat like my buddies.” Discussing the organizing principle behind the patient’s sense of shame will help both therapist and patient better understand what feels too dangerous for the patient about acknowledging a traumatic emotional state. Then, the therapist can help the patient understand and bear the shame itself before moving on to understanding the traumatic emotions themselves. As Stolorow points out, shame is a secondary emotion attributable to a lack of finding a relational home for traumatic feelings (2007). Military personnel can feel shame related to combat experience for any number of reasons. One reason might be shame due to participation in extreme violence, which is the case for Mr. A. Other reasons include that a perceived mistake caused harm to someone else, being medically evacuated from theater, the effects the traumatic emotional state has had on the patient’s relationships, being medically retired from the military because of PTSD or other problems, or being unable to function as a service member. Almost all military personnel take pride in their jobs, or being able to fulfill their roles on a team. In such situations where shame is
causing high resistance to treatment, the course of therapy may have to be lengthened to allow time to process it adequately.

The therapist’s sense of shame or shaming of the patient can also cause problems in the treatment process. The therapist might feel guilt and shame because of what the patient has endured while defending our country. Alternatively, the therapist might not be able to tolerate hearing graphic details of horrific acts the patient has done or witnessed in combat. A major difference between treating military personnel for traumatic experiences and civilian trauma is the role of the patient in the violence. A service member may be both victim and perpetrator of violence and may have very little remorse about killing or harming others in combat. Hearing these acts, along with the patient’s frequent reaction of pleasure at the violence itself, can be difficult for many therapists to bear without withdrawing from the patient or casting a judging gaze. But those reactions are enactments of the malattunement from others that originally created the traumatized state for the patient. At those moments, the therapist needs to focus on understanding the context of the violence and the feelings of the patient from a stance of empathic introspection. Many narratives of combat or other violence are difficult to hear. Therapists, therefore, should engage in treatment themselves to help reduce the effects of vicarious traumatization and to reduce the risk of shaming a patient.

Another shaming experience for the patient occurs when the therapist minimizes the patient’s traumatic experience. The therapist may feel that the combat events the patient describes are not sufficient to cause the level of distress the patient is exhibiting, or the patient does not appear to be sufficiently distressed to “rise to the level” of a PTSD diagnosis. I feel these reactions of therapists miss the point of traumatic experience. There are varying degrees of exposure to violence while serving in a combat zone, from killing other people in urban combat to a few random mortars landing on a large base. Reactions seem inconsistent with the level of violence because the violence is not the traumatic event. As Stolorow describes, the trauma is the emotional experience arising from the event and the inability to find a means to process it with others (2007). Therapists who lack this understanding of trauma can easily shame a traumatized individual: the person’s trauma story does not seem to “measure up” to that of the last patient in the consulting room. This skeptical approach often leads to suspecting that most patients are exaggerating or faking traumatic exposure for secondary gain. It might also be a sign that the therapist is overwhelmed and suffering from vicarious traumatization.

**Mr. A: Shame Addressed, a Confession Begins**

At our first therapy session after the consultation, I had to overcome an initial disjunction with Mr. A that occurs frequently when working with traumatized military personnel. Because of shame and a sense of isolation from “the normals,” they often believe that only a combat-exposed person can understand combat experiences. With Mr. A, his shame manifested as a fear of being charged for war crimes if he revealed his actions. Even in the initial consultation, I approached this fear and shame with concrete reassurance that my top priority was to help him. However, I also included some evidence that I might be able to understand what he wanted to discuss. My approach was more active, trying to accelerate the development of an intimate relationship. We had relatively little time. I also maintained a focus on an empathic stance while thinking about Stolorow’s idea of the loss of temporality. Here is an excerpt from that session:

P: I really need to confess these things, but I fear telling anyone.
T: What do you fear?
P: I did some terrible things, maybe war crimes. I fear I’ll be tried for war crimes if I talk.

T: That must feel like a very difficult spot for you. I want to reassure you that I’m not here to catch anyone. I’m here to help you. I don’t know your specific experiences, but I’ve treated a lot of soldiers and Marines where I work at Walter Reed and the Naval Hospital in Bethesda. I’ve also been out here, but everyone’s experience here is different. What we can try to do together is to understand your experiences, and help you reconnect with other people, starting with me. One common problem that people who have survived horrible trauma describe is the loss of a sense of time. One author I’m reading now talks a lot about that, and I’ve heard it from other soldiers. Sometimes, when you feel like others can’t understand your experiences, it might be because part of you is still trapped in that time, unable to connect with the present.

Through this disclosure and discussions about the nature of trauma, Mr. A began to believe that I might be able to understand him and the process of reconnection with another human being began. One might say that I then appeared on his subjective horizon. He then went on to discuss some of his experiences that he had never disclosed to anyone else. He described how during his last deployment he operated a machine gun on top of a vehicle. His unit was involved in an offensive to take a city back from insurgents. He said they were told that, because leaflets were dropped on the city warning all noncombatants to stay inside, anyone on the street should be considered the enemy. During part of the battle, a car came toward his vehicle. Mr. A could not see who was inside it, and it wasn’t stopping. He was terrified. He opened fire, catching the vehicle on fire and hitting the passengers. He learned later that they were two women and a man, probably an Iraqi family. But his shame wasn’t only about shooting into a car and killing two of these people. It was his reaction to finishing off the survivor. The driver of the car had managed to crawl out. He lay beside the burning car, moving slowly, and with fire burning his legs and back. Mr. A saw him moving, and then killed him with another shot. As the body continued to burn, he smelled the cooking flesh, and realized he liked it. He said it made him feel hungry, along with another sense of liking it that he couldn’t describe. It was his horror at himself becoming so savage that Mr. A wanted to confess. Instead of violating the laws of armed conflict, he seemed to fear that he had violated the laws of being human. By the end of the discussion he was crying. As I tried to comprehend these horrific events and the feelings behind his confession, I focused on empathically trying to understand and thus bear the burden of this shame with him. I hoped to help him process these sorts of events, and wondered if I could tolerate his narratives for the coming months. As he began to cry at the end of his confession, I thought of Stolorow’s descriptions of the loss of “absolutisms” of everyday life. I described this idea to him as I thought it might relate to his experience: “That experience must have been horrible for you. You’ve had to face a savage side of you that is in all of us. It is there in all of us, most of us just don’t have to acknowledge it. Experiencing it can make people feel separate from everyone else. You’ve realized how fragile life is, especially the ‘normal’ life that most Americans live back home.” He responded with “Yeah, you get it.” He was connecting with me and we were processing his experiences together. I praised him for the courage to share such difficult experiences. During this session, I did not feel repulsed and did not try to construct an intellectualized understanding of his intrapsychic mind. As authors such as Boulanger (2007) have described, attempting to link such traumatic experiences to a patient’s childhood, as is typically done in a classic developmental-based psychoanalytic understanding, can too easily minimize the impact of traumatic experiences that occur in adulthood. Instead, I focused on an empathic introspective stance to understand his
experiences of the traumatic emotional state. I felt more connected to him than to almost any other patient with whom I had discussed such traumatic experiences. My attempts to accelerate the work we were doing appeared to be on track. As the session ended and he left, I felt a much stronger connection with him than when it began, and a sense of privilege that he felt safe enough to share with me such personal anguish.

Phase 3: Sessions About the Phenomenology of Trauma

One might argue that dealing with the shame of the traumatic experience can be the bulk of the therapeutic work. Overcoming this shame can allow the patient a sense of safety, or freedom from danger, to discuss the traumatic emotional experiences themselves. Once initial shame is addressed and confessions of events occur, the next phase of the therapy in this model focuses on understanding how the traumatic emotional experience from those events has impacted the patient’s life. As discussed earlier, Stolorow has very articulately described what he feels are common subjective experiences of the impact of trauma in his book *Trauma and Human Existence* (2007). Because it is a short-term treatment model, the therapist does not have time to remain passive and await these or variations on them to appear gradually and then identify them to the patient. Instead, these must be actively discussed, even sought out, as the patient and therapist overcome shame and tolerate discussing them. It is the therapist’s role to educate the patient about them as possible experiences, and then explore how these explanations fit or don’t with the patient’s own experiences. This will probably feel a little like psychoeducation initially with the patient, and it is in some ways. But the major difference here is that the ideas, such as the loss of absolutisms, is conveyed with an attitude of fallibility. The therapist does not say, “This is the way it is for everyone and so this is what you are experiencing.” Instead, they are presented as understandings of what can happen with trauma, and then the patient can be asked if they resonate with any of his or her own experiences. This approach must be couched in an empathic stance with the patient, with a sense of learning from the patient. In my work with service members, this approach has frequently opened up areas for us to discuss that patients had not previously been able to verbalize. They created a reassuring sense for patients that I “got it.” Stolorow’s descriptions may not exactly fit the patient’s experiences, but they can start a dialogue. Putting language to feelings and experiences with another person, with these descriptions from Stolorow as a starting point, is what the patient needs in order to bear traumatic emotions. If I describe one of these areas of experience to the patient and it does not resonate, I will frequently bring it up again if the patient describes an experience later that I feel depicts the idea, and then we discuss it further. In this way, the patient feels understood and the discussion may begin a connection within which the patient and therapist can together create a relational home. I feel these phenomenological descriptions are some of the most important insights that Stolorow offers about traumatic experiences, in that they provide insight into the traumatized world for the therapist, so that a dialogue about those experiences can begin.

There are many examples of how traumatized military personnel experience the phenomenology that Stolorow describes in *Trauma and Human Existence*. For instance, military personnel who deploy together, and are particularly in high-risk situations or see combat together, can experience each other as “siblings in the darkness.” They may feel that no one else “gets it.” In a positive light, they may find in this closeness a means to process and bear their feelings about their combat experiences with each other. On the other hand, one of the group’s members may feel completely devastated and alone if forced to leave the group or to let the group down (i.e., not being allowed to deploy again
with the unit). Another area is the loss of temporality. Some might describe them as "flashbacks." In such extreme experiences of the loss of temporality, it is impossible to escape the past. Time collapses to the time of the emotional trauma. There is no present, so there is actually nothing to flashback from (Stolorow, 2011). For example, some soldiers I have treated back in America have refused to sit near windows after returning home. They would explain that they knew that they were no longer in Iraq but could not stop feeling that there were snipers on the rooftops. Another manifestation of Stolorow's phenomenology relates to the Being-toward-death and the subsequent sense of isolation and disconnection from the daily concerns of the "normals," or what Stolorow calls the "publicly interpreted everyday world" (Stolorow, 2007, p. 38). Many service members dealing with traumatic experiences describe feeling "done" with the military. They frequently were career soldiers who now are waiting for the opportunity to leave. In the case of Mr. A, he next refuses to participate in military operations. In his case, this acting out was not a sign of worsening PTSD but was actually evidence of him becoming more connected with the present again in authentic resoluteness and realizing what he held as important.

Mr. A's Experience of the Military

There was a week-long hiatus after Mr. A's first therapy appointment because of mission requirements. When we resumed, he presented new material from his first deployment. But we struggled to focus on any particular event. Mr. A said he didn't want to waste time on unimportant things. He described several more violent scenes, including one in which he was almost shot. He also began to describe more of his feelings about the war in Iraq. At the beginning of one of these sessions, Mr. A informed me that he had decided he could no longer participate in the missions of his current unit in Iraq. He had routed a memo requesting to be released from theater. He described how he no longer saw this war as worthy of any sacrifice, much less that of his own life. He would request to leave Iraq, and if he were not allowed to leave, he would then refuse to participate and bear the consequences. Mr. A said his wife had asked him in an e-mail a few days earlier "why now?" did he choose not to participate, and not before returning to Iraq. He told her that his mind had been in a haze. He had felt this way for a while, but he had been unable to act on it. He felt that he was now coming out of this haze and could act.

I was taken aback by this decision to stop his participation in the conflict in Iraq. I feared that it would lead to him going to jail, ruining his life, or getting kicked out of the military. Yet I also recognized his refusal to participate resonated with some of my own organizing principles in an important way. I didn't agree with the war, but I was going along with it. I wanted him to do the same. Thinking intersubjectively, had I somehow conveyed my real feelings about the war to him and thus contributed to Mr. A's decision? I began to fear that maybe Iraq was too harsh of a place to work this intensely with patients after all. I also felt a little self-conscious: how would this reflect on me as a therapist with his chain of command and with other providers? I imagined the scenario of my peers noting that his refusal to participate in missions and an imagined future meltdown began only after we started treatment. With all of these feelings, I realized then that I had to understand my own organizing principles and what I might bring to our work together in order to treat him effectively. After some reflection, I also recognized that, regardless of my feelings about the outcome, he was finally processing his traumatic experiences. He was beginning to develop the resoluteness that Stolorow (2007) describes as integration of an unbearable "being-toward-death" into one's experiential world. He was working
toward constancy in his emotional world (or sense of agency) rather than succumbing to dissociative numbing. But in spite of this intellectual understanding of his actions, I entertained a fantasy that if I were able to interpret to him that his request to leave Iraq was actually an enactment of feelings from his prior deployment, then he would somehow be free of it and conform. I did not consciously want to persuade him of this, and I knew that I would have to keep the potential for such a disjunction in mind if problems arose.

In a practical sense, Mr. A’s refusal to go on missions brought up his duty status. Was he psychologically fit to be on full duty, meaning to do what he was refusing to do? I began to realize that his care would require me to communicate with his chain of command in some way. I would typically do this by recommending restrictions on a service member’s duty. I did not honestly feel, however, that his PTSD symptoms were, by now, of such severity that he could not function. His refusal to go on missions was volitional and might get him into trouble. I was transparent with him about my concerns. He refused a profile from me limiting his duty status, saying that he was feeling better not worse. He did agree, however, for me to speak with his company or battalion commander if they called me about him. Although I am required to give basic information about a soldier’s care to his or her Commanding Officer, I always talk to the patient about releasing any information and usually get his or her written permission to protect the patient’s sense of privacy. I convey to them that my intention in releasing any information outside of what is required is to advocate for them. In this case, Mr. A had already told his chain of command that he was seeing me for therapy, and he knew they would be contacting me. When I spoke to his Commanding Officer, he was quite sympathetic to Mr. A because he knew that he was in Iraq on a “stop loss” status, and simply wanted to confirm that I felt he had PTSD from his prior deployment. His CO decided to tolerate his refusal to participate and reassign him to duty in their command post on base.

In the spirit of increased therapist activity as part of short-term therapy, I continued to discuss with Mr. A over the next several sessions the intersubjective conceptualization of emotional trauma, based on my understanding of Stolorow’s Trauma and Human Existence. These sessions were in part psychoeducational, but I never told him what he was experiencing. I offered these concepts as possible descriptions of experience. Together, we explored how they might relate to his current organizing principles. I continued to monitor for any recurrence of shame for either of us. Based on exploring these concepts, we had discussions that sometimes reinforced for him that he was not unique in his experiences. Our work together, with these ideas about trauma as a basis, gradually undermined his “excruciating sense of singularity” (Stolorow, 2007, p. 14). These topics also gave me access to parts of his experience that he said he had never shared with anyone else.

Instead of giving examples of our discussions of Stolorow’s ideas on the phenomenology of trauma, I’ll focus on how those ideas led us to “an intersubjective key” that unlocked a tremendous loss for Mr. A and helped us to bear briefly together his overwhelming emotional experience of it.

**Phase 4: Seeking an Intersubjective Key With the Patient**

This is another phase that may prolong the therapy (addressing shame is the other one), and it is probably the most important for the treatment to be effective. The problems arise in finding this piece of information and the affects attached to it, recognizing its significance, and then responding in a way that helps the patient bear it. It can also be some of the most emotionally difficult work for the therapist.
An intersubjective key refers to a highly contextualized, individualized comment that opens the full emotional impact of the patient’s traumatic experience (Stolorow, 2007, p. 26). Its power lies in reconnecting the dimensions of time for the patient, bringing a meaning of the past to the present and future. The connections in meaning that it makes for the patient help to reestablish a sense of being-in-the-world again. It alters the state of ontological unconscious, or the sense of a loss of being. It gives the patient a language through which he or she can express the most traumatizing of emotional experiences. It may appear to have little to do with the events or actions that the patient initially wants to confess, because shame can often prevent the patient from sharing the most troubling emotions.

The discovery of an intersubjective key often begins with the therapist verbalizing a connection that the patient had not previously made consciously. One might call this an interpretation, but it is not bringing something from the unconscious to consciousness in the same topographic way as the traditional use of this term denotes. Instead, it facilitates the verbalization of emotions for which, up to that point, the patient had found no language. As described earlier, language is essential to sharing and ultimately processing affects. As Stolorow notes, “it is in the process of somatic-symbolic integration, the process through which emotional experience comes into language, that the sense of being is born.” (Stolorow, 2007, p. 30). An adult without significant developmental trauma most likely has the ability to verbalize most emotions, but this traumatic experience is one that the person has failed to put into language. A therapist providing a way to verbalize that emotional experience through an intersubjective key is an excellent example of how attunement from the surround (other people around a traumatized individual) helps to bear and process trauma.

Finding such an intersubjective key can be the difficult part. I have found that it often appears unexpectedly, several weeks into the therapy. Its appearance, like all aspects of therapy from an intersubjective perspective, is codetermined. Through the work of understanding the dangers and shame that the patient feels about revealing emotional states, the therapist and patient have created a relationship in which they can give words to the patient’s most intense emotions. Relying on the basic principles of following affect and an empathic introspective stance are essential in recognizing an intersubjective key with the patient as it appears. Frequently, it can be found when something is mentioned that had never appeared in the therapy before: discovering that a friend frequently discussed actually died several years ago, or a piece of the patient’s narrative account of an event that is new. The absence of some portion of the patient’s narrative of traumatic events or experiences after them might provide a clue. Once it is found, intense emotions frequently arise within this new relational home. The therapist must recognize the need in the moment to bear these feelings together and hopefully can maintain an empathic stance with the patient through this emotionally painful experience. Failing to recognize the gravity of this moment could be catastrophic to the therapeutic process, because the arrival of it and bearing it together are inseparable. Identifying an intersubjective key and then failing to bear the traumatic emotional experience together might create a severe resurgence in shame for the patient. Again, this is why maintaining an empathic introspective stance throughout each session is so important.

**Mr. A: Death of a Friend**

About a month into the treatment, Mr. A described his overall frustrations and feelings as they evolved through his previous year-long deployment. He was struggling with where
to begin. We often sat in silence the first few minutes. I would encourage him to focus on emotions, trying to trace the evolution of his sense of loss of time and separateness from others since his previous deployment. I felt I was trying to follow Stolorow’s ideas in an active way required for short-term therapy. I was trying to intervene and talk more than I normally would. Mr. A followed the lead well. He focused on his anger toward his squad leader, who, Mr. A felt, did not pay attention to their surroundings enough during the retaking of the city. He felt this person almost got them killed a few times. Mr. A yelled at him at one point during the battle. Through empathic introspection and following his affect, this frustration toward his squad leader led to a piece of information Mr. A had not previously shared with me. I was not expecting it, and it became “an intersubjective key” that revealed the relational underpinnings of his emotional experience of trauma. I’ll present that part of the session at the end of the next section.

**Phase 5: Providing a Relational Home**

Helping the patient bear, process, and integrate emotional trauma is occurring throughout the course of the treatment. This perhaps reaches a peak when an intersubjective key opens up an area of experience that the patient had, up to that point, found no words to convey, no attunement for it from others. These are often exquisite painful feelings that can carve out a gap in the patient’s narrative and that create tremendous shame. When the patient is in this level of emotional pain with the therapist, the relationship can only be between two frail humans caught in the same finitude, and not that of a hurting patient and an all-knowing, distant therapist. Empathic introspection may lead the therapist into crying with the patient or offering a hand to hold as they bear the pain together. Of course, this is not to say that the therapist is now “inside” the experience of the patient. The therapist does not experience the same emotions as the patient. The therapist, however, must be, just like the patient, a human being, sharing in the room with the patient his or her exposed pain and terrible vulnerability. I suggest that, whatever emotions the therapist shows in these difficult moments, they must be for the benefit of the patient. The emotions must emanate from within an empathic stance toward the patient. The therapist’s emotions must also be from a shared experience with the patient, the putting to words together of the previously unbearable emotions of the patient. The therapist cannot during this time allow his or her own traumatic experiences to emerge. They might have been useful in the early stages of the therapy to help the therapist “get a foot in the door” with the patient, but now in such a difficult moment for the patient, the focus must be on attunement, bearing the patient’s traumatic experience together. When therapists get into trouble for crying or otherwise showing emotions in therapy, I think it is because the patient recognizes that the therapist’s emotional state is a result of the emergence of the therapist’s own trauma. This is another reason why, as described earlier, therapists must have processed their own emotional trauma in order to engage well in this work. Additionally, with such exposed feelings, the patient will also be very vulnerable to shame. The therapist will need to be careful at that time not to reject or minimize the patient’s feelings. I also usually remind the patient how I can be reached and offer additional sessions during this time.

The intersubjective home for the patient’s intense emotions becomes one of the major sources of therapeutic action. It affects all areas of the phenomenology of trauma. It does so by helping the patient bring language to previously unprocessed emotions or affects, and then giving the patient a sense that he or she is not alone in the traumatic emotional experience. It reopens a connection for the patient with another person. This relationship
with the therapist then can be the first of additional relationships to form over the coming months after therapy has ended, as the patient can once again spend more time in the present. Mr. A had already begun to experience some of this awakening from his traumatizing past, and verbalizing what was probably at the heart of his traumatic emotional experience, the death of his friend, created an even stronger sense of constancy in his experiential world. He was then able to express being ready to terminate with me and focus on building a new life.

What Mr. A Had Not Wanted to Confess

P: I had really wanted to change vehicles. I even looked into it. But I decided I couldn’t. I didn’t want to leave Tom (fictitious name). He was my best friend. I was there to protect him, even from our squad leader. That was what I saw my job as up top on the truck.

T: It sounds like you cared for him more than your own life. You thought your squad leader might get you killed.

P: It was my job to protect him. I could not leave him.

T: Are you still in touch with him?

P: I stayed in touch after I got home from Iraq, but lost touch when he deployed again . . . He was one of the few I could talk to . . . I was struggling when I got back home. I was working and dating my wife then, but I was drinking a lot and was feeling irritable, in a haze. I was at work when my mom called me and told me. He had been killed in Baghdad. His truck hit a roadside bomb. I felt so guilty. I should have been there with him. I should have been there to spot the IED. I was a pull bearer at his funeral. Since then, some other guys and me get together at his grave every year on the anniversary of his death. I’ll miss it this year. I had things I wanted to tell him.

T: What would you want to say to him?

P: (getting tearful) I should have been there for you . . . I . . . (he tried to continue but began crying.)

We were both tearful. We sat without words while he cried. This was not a time to explain to Mr. A how death is fundamentally relational. He already knew this. We were sharing his overwhelming loss and our common finitude. Tears were rolling down my face. I did not ask him, but he seemed to experience my crying as attenuation or twinship, not as him overburdening me or me reexperiencing my own trauma. We were sharing a deep emotional bond that Stolorow describes as a place where “devastating emotional pain can be held, rendered more tolerable, and, hopefully, eventually integrated” (Stolorow, 2007, p. 49).

Phase 6: Terminating and Both Moving On

The time to terminate seems to come quickly for me in short-term therapy. I would enjoy getting to know the patient even more, focusing on any problems from developmental, or childhood, concerns. However, the stop date for therapy is frequently firm in military settings, either because of the therapist or patient moving or mission requirements. The therapist should have termination in mind all along the way in this form of therapy, because it is brief and must be focused to reach its goals. I have found that for many military members who seek treatment for combat-related PTSD and had no prior psychiatric concerns, they look forward to termination. It sometimes seems more difficult for me than for them. As I said in the beginning of this paper, fix it and move on is the mentality.
Termination is a time for the therapist to recognize that the patient is improving. The patient should be able to express an understanding of the nature of emotional trauma, what improvements have occurred, and what should occur in the future. In the content of sessions, when it is time to terminate, the topics that emerge for discussion may sound unrelated to the traumatic experience that both parties had agreed would be the focus of therapy. There may be problems in these other areas, but to address them will require both the patient and therapist to recognize that they are moving together into areas outside the original goals of the therapy. Both should acknowledge that, with that movement to other topics and goals, a different treatment is starting. This may happen: short-term therapy may become long-term therapy to address longer-standing concerns, or it may become a referral for couple therapy as the patient decides he or she needs to focus on the marriage now. Any of these indicate that the original problem that led to therapy, a traumatic emotional experience, has been addressed. If problems are persisting as termination nears, I reconsider the therapeutic process. I consider whether or not both the patient and I have engaged actively in the treatment process, and if not, why not? I also consider whether there are other factors that have not been addressed, such as substance abuse.

The End of My Work With Mr. A

Over our last two weeks of therapy after finding this intersubjective key related to the death of his close friend, Mr. A changed. He said he wanted to stop his paroxetine, feeling he did not need it any more. I agreed with the caveat that anger might continue to be a problem for him. He agreed, but felt that the anger was now with himself for “wasting the past three years.” He seemed to be out of the haze that brought him to therapy and was assessing the consequences of lost time. I tried to support him from his despair and new shame over his PTSD, and refocused him on his ongoing efforts to express himself now that he felt he was out of his haze. He discussed how he had put some of his efforts to leave Iraq aside for a new project about staying in contact with home. Each unit has a spouse network that organizes activities and puts out information. He and others felt that his unit’s network was doing poorly and sought a change in its leadership. Mr. A had asked his wife to take up the cause. On the Iraq side, he would also be involved in putting together a newsletter for the families back home. I realized he was pursuing what really mattered to him now: connection with his wife and home. He was functioning better and not flailing in his anguish. I encouraged him by observing that he seemed to have taken up an important cause for himself and the Army, and was “fitting in.” He agreed it was mutually beneficial, but shied away from the desire, implicit in my question, to fit him into the system. Unintentionally, at least on a conscious level, some of my own feelings that challenged his stance toward the Army were clearly present, but I felt comfortable enough in the moment that they might help illuminate some of his feelings about his military service. I then asked about the role the Army will play in the rest of his life after he returns home, thinking he would want nothing to do with it. To my surprise, he said he wants to be buried some day in a flag-draped coffin just as his friend had been. I observed aloud that his experiences in the Army must be important to him, and he said he would never forget them. He also discussed more positive things, such as friends with whom he was still in touch. He planned to meet one of them when he would return to America on R&R in a few weeks and also planned to visit his friend’s grave. He appeared to be processing his traumatic experiences and integrating them into an overall meaning for his life.

When we had our final session, we drifted among topics. Mr. A said he felt there was little left to discuss about our agreed focus for treatment: his emotional trauma from his
last deployment. We ended with a discussion of what he hates about the Army: religion. This touched on an experience he had before he enlisted in the Army. His father forced beliefs on him during a summer Presbyterian Church program while in high school. I realized as the discussion rolled along how far away we were from the smell of burning flesh or the death of best friends. He was speaking of things that we “normals” fret over. There was some discomfort for him in what he described, but that day was not the day to address these longer-standing organizing principles. His traumatic experiences were now better integrated into his emotional world. He was once again facing similar problems that he had before the trauma, but now with a new perspective. We ended and he walked back to his unit. I wanted to watch him walk away from the clinic, but another soldier was waiting for me when I opened my door.

Mr. A and I achieved our therapeutic goal together by sharing our common finitude and by me providing twinning to his traumatic emotional experiences. Through this deep emotional bond, he once again connected to another person, integrated his traumatic emotional experiences, and started to regain a sense of constancy in his emotional world, including his selfhood. Over time, primarily as the therapy was terminated and afterward, the patient began to reform meaningful relationships with others and hopefully gained both a sense of agency and a sense of what really matters for him. When I contacted Mr. A about six months after our last meeting to get permission to write about our work together, he told me that he had just returned home from Iraq for good, having completed his deployment there. He was doing well.

Stolorow’s Ideas and the Relational Literature on Trauma

Of course, Stolorow is not alone in writing about trauma from an analytic perspective, but he is one of the few to write about adult-onset trauma. Historically, the vast majority of psychoanalytic writing on trauma has been focused on the effects of developmental, or childhood, trauma. There are a few notable exceptions, including Freud (Freud, 1955) and Fairbairn (Fairbairn, 1952), who addressed combat-related trauma. Unfortunately, almost all writers required some form of developmental predisposition in order to develop problems, such as “combat neuroses,” in adulthood (Boulanger, 2007). Contemporary writers besides Stolorow have described the treatment of trauma in adults, but most of them focus on work with adult survivors of childhood abuse. There are several excellent examples in the relational literature of depictions of the aftermath of childhood trauma, including writings by Jody Davies (Davies, 1996; Davies & Frawley, 1992; Davies & Frawley, 1994), Philip Bromberg (Bromberg, 2003a; Bromberg, 2003b), and Judith Herman (Herman & Schatzow, 1987). Herman has also written a well-known, comprehensive book on trauma: Trauma and Recovery (Herman, 1997). Unlike these writers, most of Stolorow’s writings have, until recently, been about intersubjective theory itself, and not focused as exclusively on trauma as their work. Only in the last 15 years has his work focused on trauma, but, unlike most writers, he describes both developmental and adult-onset forms. A full review of the work of these other relational writers on trauma is beyond the scope of this paper. Nevertheless, a brief discussion of Bromberg’s ideas, and how they compare to those of Stolorow, will enrich our psychoanalytic conceptualization of adult-onset trauma.

Bromberg’s ideas about trauma have significant overlap with those of Stolorow. Although Bromberg writes from an interpersonal perspective that focuses on the disassociated “not me” described by Sullivan (Sullivan, 1953) and other contemporary writers
(Stern, 2009), he agrees with the centrality of affect and shame in contributing to traumatic experiences. He describes trauma as the overwhelming affect related to an event, and not the event itself. In a similar way to Stolorow, he describes how “the failure of the interpersonal pattern to provide the needed soothing leads to profound impairment in affective self-regulation” (Bromberg, 2003a, p. 691). Both agree on the need to focus on the patient’s inability to discuss material in sessions but have somewhat different conceptualizations of this problem. Stolorow sees the key to understanding such resistance as understanding what unconscious organizing principle, or pattern of experience, holds influence within the specific intersubjective field between the analytic dyad and fosters feelings for the patient, such as fear and shame, about discussing the topic. Bromberg, on the other hand, describes it as the patient’s need to defend against working in the transference:

It is my belief that a patient’s so-called inability or unwillingness to “work in the transference,” such as described by Yovell, is directly tied to the person’s reliance on dissociation as a means of foreclosing potentially traumatic encounters with the mind of a needed other in the here and now—encounters that could threaten to trigger affective hyperarousal, including shame, without hope of regulating the affect through the relationship itself (Bromberg, 2003b, p. 561).

Shame about overwhelming emotions is extremely powerful to Bromberg, and he, like Stolorow, describes how it frequently leads to dissociation and other disruptions within a therapy (Bromberg, 2003a). A major difference between them is Bromberg’s emphasis on the universality and frequency of dissociation and multiple self states for all people. Both therapist and patient must work interpersonally to overcome this dissociation of their own unwelcome feelings in sessions in order to have a more genuine relationship and to help “what is dissociated to become symbolized and available to conflict resolution” (Bromberg, 2003b, p. 558). Whereas Bromberg seems to describe therapeutic action as bringing these dissociated feelings to a conscious level of conflict that is then open to change and possibly resolution, Stolorow seems to focus on providing a relational home itself as the therapeutic action (Stolorow, 2007). Stolorow instead emphasizes understanding the subjective experience of traumatic emotional states, with such ideas as the ontological unconscious. Both use in their work a relational home to bring language to dissociated emotional states, but Stolorow focuses on the relational home as therapeutic whereas Bromberg considers the transformation of unconscious “not me” affect to felt conflict the therapeutic action. These differences between these two writers, who are giants in their field, seem more about emphasis than conceptualization, making their approaches more complementary than contradictory.

Interestingly, Bromberg, like Stolorow, sees trauma as universal. He makes an argument for the universality of having the capacity to deal with trauma, because “the presence of trauma and dissociation is to be found in the personality functioning not only of persons whose history is linked to massive physical violence or sexual abuse, but also of those who grew up without such history” (Bromberg, 2003a, p. 690). A synthesis of Bromberg’s focus on bringing the “not me” back into the self experience and Stolorow’s descriptions of the subjective experience of trauma and focus on a relational home to integrate traumatic experiences might some day yield an even more powerful theory of trauma.

A major difference with what I am describing as adult-onset trauma and Bromberg’s conceptualization is that he maintains that there is usually an early developmental trauma, which he describes both in terms of attachment and neurotransmitters, which predisposes
one to cope with distress in adulthood in pathologic ways (Bromberg, 2003a). He does not specifically state that one must be predisposed in order to experience a traumatic emotional state as an adult, but this seems implied because the patients he describes all have childhood trauma histories.

One of the most relevant contemporary writers for treatment of the population I describe is Ghislaine Boulanger (2007). Her book *Wounded by Reality: Understanding and Treating Adult Onset Trauma* is the culmination of 25 years of working with and thinking about victims of adult-onset trauma. It is an excellent work and makes a major contribution to identifying adult-onset trauma as both a separate diagnostic entity and subjective experience from development trauma. Boulanger appears to arrive at similar frustrations with classic psychoanalytic approaches as other writers, including Stolorow. She adds a few more, particularly how these approaches can blame the patient and can minimize the effects of adult trauma (Boulanger, 2007). Although Boulanger acknowledges the need for a relational, intersubjective understanding, her approach has differences from what I describe. She uses language derived from contemporary object relations theory, such as persecutory part-objects, to describe the effects of trauma on the person’s mind. I use Stolorow’s ideas about trauma and language from intersubjectivity theory to describe the patient’s subjective experience of the traumatic emotional states. Her focus is less on the phenomenology of a traumatic state and more on the effects of internalized object relation experiences.

As this brief overview shows, many of these contemporary writers on trauma have several commonalities, in spite of working within different psychoanalytic paradigms and with different patient populations. One of these is the importance of the relationship for the traumatized individual, both to help reduce the effects of a traumatic experience and to provide the means of processing it in therapy. They also emphasize the importance of language, giving words to a traumatic experience as a means to process it. Lastly, they all describe dissociation as the primary response to an unbearable traumatic experience. Stolorow has some differences with them, primarily, in focusing on the phenomenology of a traumatic experience in adulthood, and how to process and integrate unbearable affects from a framework of intersubjective systems theory. In my work, I have attempted to synthesize Stolorow’s ideas on adult-onset trauma into a short-term treatment paradigm for combat-related PTSD. Perhaps future studies, even discussion groups and organizations, can establish research and scholarly activity to address the differences in the variety of relational approaches to trauma and develop an integrated approach to adult-onset trauma.

**Conclusion and Future Plans**

I hope this article has given you a glimpse into working with combat veterans from an intersubjective perspective. This article is the start for me of developing a short-term intersubjective therapy for combat-related PTSD. I hope to complete a more thorough proposal for this kind of work that other providers can apply when working with veterans suffering from combat-related PTSD and possibly when working with adult-onset trauma victims in general. A short-term intersubjective approach that is developed for military populations may also be generalizable to other groups who cannot participate in long-term therapy.

As with other larger medical systems in America, the Department of Defense and Veterans’ Administration mental health care systems emphasize empirically supported
treatments and guidelines. The VA/DoD Clinical Practice Guideline for PTSD, published in 2010, lists brief psychodynamic therapy as the only form of psychodynamic therapy recognized to offer some benefit for PTSD. Even though it is listed, it is given only a “C” rating for evidence, with the highest “A” rating going to forms of cognitive and exposure therapy (2010). Within empirical literature, psychodynamic therapy is considered to lag far behind other forms of therapy in demonstrating utility in the treatment of PTSD. However, researchers have shown that there is still a significant drop out rate with many of the established forms of cognitive–behavioral therapy for PTSD (Schottenbauer et al., 2008), indicating a need for further investigation into treatments for this illness.

In order for a short-term intersubjective approach to gain acceptance among providers with diverse theoretical orientations within a large system like the Department of Defense or Veterans’ Administration, it will need to be researched and communicated in a manner that is accessible to providers without significant analytic backgrounds. To close any gaps in acceptance between such an approach and cognitive therapy and to make it accessible to providers without extensive backgrounds in analytic and philosophical ideas, descriptions of it will need to be formulated and marketed with minimal jargon in order to create a bridge of understanding for therapists who are unfamiliar the psychoanalytic literature. Additionally, there are several areas of research that might be helpful in developing and testing an intersubjective approach. Although Stolorow elaborates very insightful phenomenological descriptions of the experience of trauma, this phenomenology could be researched further to understand better some common traumatic emotional experiences that are specific to combat. One possibility for this work will be phenomenology research that interviews military service members with PTSD, and even comparing their experiences to what Stolorow describes. Manualization of short-term intersubjective therapy will also prove beneficial for its refinement, testing, and possible dissemination. Once this therapy is built on phenomenology specific to combat experiences and then described in detail for ease of replication, it can be tested in empirical trials. These trials should occur in military treatment facilities, preferably ones near large active duty populations that have completed several deployments. Research trials will help in further development, in determination of its efficacy, and in gaining recognition. These can start as case series and then open-label cohort studies or efficacy trials. Such smaller-scale research will test the approach scientifically and further hone it. Eventually, if it appears efficacious, it can undergo randomized controlled trials, perhaps with cognitive models as the control. Smaller comparison trials might eventually be possible in combat zones. I feel that, through immersion into the empirical research world, an intersubjective model can be further refined and also reach providers outside psychoanalytic circles. Research on the role of intersubjective therapy in the treatment of PTSD is needed.

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