The Case of The Soldier Who Failed to Return: Reflections on Psychodynamic Psychotherapy with Combat Veterans

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Abstract

The effects of war on combat veterans' mental health are numerous and well established. Several effective interventions exist based on cognitive–behavioural therapy that aim to reduce the symptoms of anxiety, depression and PTSD that many veterans struggle with. However, little attention has been paid to psychodynamic psychotherapy and documenting its use in treating the sequelae of war trauma. Furthermore, very few writings discuss how working with combat veterans within a psychodynamic framework can affect the therapist. This paper presents the case of 'Sam', a combat veteran who suddenly disappeared from psychotherapy after some years in treatment. The author reflects on the issues that arose in this course of therapy with the aim to stimulate further reflection in practitioners working with veterans drawing upon a psychodynamic model. It is hoped that readers and organisations supporting veteran mental health will develop an appreciation of the intricacies of psychodynamic psychotherapy with combat veterans, understand the importance of the therapeutic alliance, appreciate the impact that working with combat veterans may have on themselves and the importance of seeking and maintaining high-quality supervision and reflection.

Keywords: Combat, Veteran, Psychodynamic, Psychotherapy, PTSD, Trauma

Introduction

The recent and prolonged wars in Iraq and Afghanistan have brought into stark focus the effects of modern warfare on combat veterans' psychological and physical functioning. Defence forces and civilian support agencies in various countries are being confronted by modern warfare's complex and enduring effects on soldiers. Psychotherapy for combat veterans is necessarily an expanding focus for research and practice driven by the need to address mental health problems resulting from the sequelae of war and occurring in large numbers of military personnel.

The impact of combat experience has been recorded across numerous conflicts throughout the 20th and 21st centuries.[1–3] Recent data compiled by the Australian Defence Force suggests that up to 54% of military members may experience some form of mental health disorder in their lifetime.[4] It is estimated that approximately 8% of Australian Defence Force members will have experienced post-traumatic stress disorder (PTSD) within the last 12 months.[4] Closely linked to PTSD is the concept of moral injury, which has seen a surge in research and the development of psychotherapeutic interventions in recent years.[5,6] While the statistics vary widely, it is clear that many soldiers who have been exposed to overseas, warlike service and combat conditions *are* likely to experience some form of psychological disorder throughout their lives.[7] Therefore, developing effective therapeutic interventions for depressive, anxiety and traumatic stress disorders is of high importance. Given the dearth of psychodynamically informed papers for combat trauma, as well as case studies and therapist reflections, the author has taken this as an opportunity to present a typical case based on years of working with combat veterans.

This paper is by no means a criticism of manualised cognitive–behavioural-based trauma therapies (CBT), which have a well-established and deserved place in trauma work. It is hoped that this case will encourage comment and reflection from therapists working with a new wave of veterans. The author hopes that these honest reflections will contribute to a deeper understanding and appreciation of themes and interactions that emerge both for the veteran and the therapist within a psychodynamic

framework and ultimately contribute to the broader development of the trauma therapy field.

Studies into the treatments for combat-related trauma come largely from research into the effectiveness of manualised (usually based on cognitive–behavioural theories) interventions.[8–10] Australia's more recent military involvement in the Iraq and Afghanistan conflicts has led to mental health workers drawing upon various manualised psychotherapies to treat veterans diagnosed with traumatic stress disorders, e.g. cognitive processing therapy (CPT).[10]

While trauma focused treatments derived from a CBT paradigm, including CPT,[11] prolonged exposure,[12] eye movement desensitisation and reprocessing,[13] all strive to achieve desensitisation to a trauma stimulus (physical or psychological), these approaches are not explicitly designed to explore the more inaccessible or unconscious aspects of a client's experience of trauma. Furthermore, there has been little focus on the qualitative examination of non-cognitive and/or behavioural therapies that treat the psychological sequelae of participating in war; therapies such as psychodynamic psychotherapy.[14–16]

Psychodynamic theory has its roots in the treatment of trauma, with Freud being one of the main proponents in the treatment of World War I veterans.[17] With modern-day psychodynamic therapists continuing to build on its various theoretical underpinnings, it is an approach that offers much hope in the treatment of combat veterans.[14–16]

The evidence for the effectiveness of psychodynamic psychotherapy is now well established.[18,19] Research over many years clearly demonstrates that psychodynamic psychotherapy results in significant and lasting change in treating multiple psychopathologies.[20] It is used effectively to treat anxiety, depression and trauma and help patients better understand what perpetuates their conflicts and symptoms.

Psychodynamic psychotherapy for combat-related PTSD has been considered in few papers.[14–16,21,22] Ishaq[14] offers an interesting approach to treating PTSD by examining not only the traumatic events themselves but how they interact with the early developmental experiences of the patient. Examining unconscious conflicts, defence mechanisms and counter-transference within the therapeutic frame may lead to the resolution of these conflicts and maladaptive reactions to the trauma. Kudler[15] put forward the need for psychodynamic theory in conceptualising combat-related PTSD in veterans and their families. Importantly Kudler points out that psychodynamic clinicians focus more on what makes the patient an individual rather than what a group of patients have in common. He goes on to say that 'collaboration between equals is a corrective to the pathological effects of psychological trauma'.[15(p.48)]. The capacity for both the therapist and patient (through the therapeutic alliance) to walk together through the processing of traumatic experiences and share their honest thoughts and reactions around this is very much a part of a psychodynamic approach to treating trauma. The exploration, reactions and reflections of both the patient and the therapist are vital in being able to uncover unconscious processes that perpetuate distress.

At its most basic level, psychodynamic psychotherapy works to enhance a client's awareness of the conscious and unconscious factors that maintain psychological pain. Of particular importance is the creation of a 'relational home'[23] where traumatic experiences can be held, explored and worked through. The affective experiences of the client and therapist within the therapeutic setting are treated as valuable data and used to help clients view their traumatic experiences anew. With regular therapy, they develop increasingly sophisticated ways of relating to and coping with these over time.

Cognitive and behavioural based trauma interventions such as CPT and prolonged exposure, assume that the client has complete conscious access to the traumatic experience and their reactions to it. These approaches endeavour to identify faulty cognitions and maladaptive behaviours arising from the event and challenge and restructure them. While a strong therapeutic alliance is important in all psychotherapies, these interventions do not explicitly use it as a vehicle to explore and process the trauma. The reactions, cognitions, affect and reflections of the therapist are not generally acknowledged and used in session in these manualised and time-limited approaches.

Psychodynamic approaches to trauma treatment start with the premise that many critical aspects of the trauma and reactions to it are not immediately available to the patient's consciousness. These distressing reactions, whether cognitive, emotional or physical, must be allowed and encouraged to emerge within a safe, empathically warm and predictable therapeutic relationship. Given time and space, and with interpretations and clarifications (key mechanisms of change in psychodynamic psychotherapy) by the therapist, the patient can then articulate and bring to consciousness contemplations that have been previously inaccessible. The therapist and patient work through defences, repetitions and

beliefs stemming from the trauma. The long-term aim is to emerge with a richer, deeper and more insightful understanding of the trauma, leading to the development of more adaptive and sophisticated coping strategies to manage symptoms.

This paper aims to contribute to a more nuanced understanding of the psychodynamic therapeutic process and the issues that can arise in working with combat veterans. A primary theme of this paper is to highlight the genuine responses and reactions a therapist can have when working with combat veterans. This process is sometimes referred to in terms of projective identification. The capacity to honestly reflect on one's own reactions within supervision to the therapeutic material is vitally important for both the client's treatment and for the psychological wellbeing of the therapist. Understanding this is to be as best prepared as possible in working with traumatised individuals, and therapists should understand that it is ok and normal to react to their clients and their experiences. Accepting this core part of psychodynamic therapy creates an opportunity for honest reflection on the client's responses and one's own responses. This creates fertile ground for clients and therapists to explore more deeply painful experiences that often have never been put into words before.

The fictitious character of 'Sam' described below is an amalgamation of real experiences and stories the author has worked with over many years distilled into one character. He represents a typical patient seen in therapy. Details have been changed substantially, but the themes, emotions and experiences remain the same. The author's responses and thoughts are real and presented honestly and openly. Of particular note about this case is the sudden drop of therapy by a client who had been attending for some years.

Although most therapists would expect to lose a proportion of clients to drop out,[24] the loss of a long-term client to unexplained absence can be disturbing to the therapist and a stimulus for urgent reflection. It is hoped that by reading and reflecting on this piece:

- readers will develop an appreciation of the intricacies of psychodynamic psychotherapy with combat veterans
- will become familiar with how unconscious conflicts (like shame and guilt) drive trauma-based symptoms
- understand the importance of the therapeutic alliance in making these conflicts conscious
- appreciate the impact that working with combat veterans may have on themselves and the importance of seeking and maintaining high-quality supervision and reflection.

Sam: The case of the soldier who failed to return.

Tall, strikingly tattooed and with a broad Australian accent, 25-year-old Sam presented to my office a few weeks after returning to Australia from a deployment to Afghanistan. He had been stationed in a small combat outpost for the previous 5 months. During this time, he experienced the deaths of, and injuries to, close mates and was in the vicinity of numerous explosions. He had been in multiple intense firefights with the enemy. Daily life was tough in the outpost with regular illnesses on top of gruelling heat and energy-sapping foot patrols.

Having referred himself for therapy, his initial appearance showed a high degree of agitation, and he made little eye contact for the first few sessions. He never once sat back in the chair, remaining perched on the edge as if he could spring out the door in a moment. He had to pace around the room at times to ease the pressure on his injured back. He often wore sunglasses inside and during the session. He described feeling profoundly confused and anxious. He worried he could act out violently if someone said the wrong thing to him. His sleep was poor, punctuated by intrusive dreams and agitation, and his general wellbeing suffered. His physical and psychological symptoms impacted his domestic relationship, further exacerbating his distress. His partner was expecting a second child in the coming months. He struck me as deeply loyal to his family, uniform and country and the values and moral thinking he espoused about right and wrong were well articulated and consistent—something that was probably a pre-condition for the guilt that he carried and later revealed.

The early stages of therapy necessarily emphasised the provision of a safe environment in which he could talk freely. I did not feel the need to say very much, and he readily used the therapeutic space. He began to slowly open up about being on patrol; facing the uncertainty of whether or not the next step he took would trigger an improvised explosive device (IED); seeing the severe poverty the locals lived in; seeing how the enemy hid among the civilian population, setting their deadly explosive devices in the fields, rivers and haystacks; wrestling with the vagaries of war; making the decision to shoot or not to shoot. He agonised over his decisions, often made in milliseconds and under fire.

He initially talked about his tours overseas in general terms and often hinted that there were more to his stories but would pull back when I invited him to explore them further. The therapeutic relationship formed a central part of our work and an area we regularly reflected. After a year or so of weekly psychotherapy, he eventually noted he trusted me, never felt judged and found comfort in being able to say whatever came into his mind without fear of being seen as weak or defective. He described feeling safe in therapy and recognised that our sessions differed from the brief and formal psychiatrist appointments he had every two weeks. It took him many more months before he could tell me that he was often brought close to being physically ill throughout our sessions, such was the anxiety attached to his stories and traumas. It often took him many hours to settle physically and emotionally after our sessions.

After 2 years of weekly therapy, it emerged that Sam was struggling with a dilemma. He recognised he was carrying heavy weight and crushing guilt over something he believed he had done but about which he would never truly know what had occurred. I could see that he desperately wanted to share this with me but could barely form the words. Clearly, he had been suffering for years, and while he had received a formal diagnosis of PTSD and depression (he refused medication despite being offered), having these diagnoses did not seem to fully capture the lonely torture he was experiencing. Nor did it bring him any real relief that he was experiencing something real, diagnosable and treatable. Finally, and with great effort, he revealed that he believed he had killed an insurgent during an ambush high up in the mountains of Afghanistan. As soon as he told me, I could see he instantly regretted it. Carefully and sensitively, I reflected on what had just happened, and we spent a great deal of time processing this. He revealed that he was almost certain he had hit the insurgent but never found a body. He would never know if the man he shot had indeed died. He was clearly deeply disturbed by this, and I made it clear that we had reached a vital part of our therapy together.

The end of year holidays came around, and it was a few weeks before we could recommence therapy. Sam missed his next few scheduled appointments, and when he returned, after several attempts to contact him, he appeared distant. It was difficult for him to engage with me, and I encouraged him to share his thoughts about our previous session and unexpected absence and what was happening between us presently. It was then that Sam whispered, 'I hated you for making me talk about killing that man. I hated you for the past couple of months. I was so angry with you. I hated you for what you made me do.' Initially surprised by his honesty and confidence, I spent some time exploring his thoughts and feelings around this disclosure, and the therapeutic alliance seemed stronger than ever. I was relieved we had reached another important point in therapy and that we could start to deepen our understanding of our relationship and his experience of working through his very personal and painful memories. After two more months, we returned to the story of the ambush, and I gently encouraged him to tell me more about it. With increased confidence, he did so, and even more details spilled out. I dared to think we had truly reached the core of his emotional conflicts and our therapeutic work. Unfortunately, it was after this session that Sam did not come back to therapy. Weeks went by, and he did not respond to my attempts to contact him. It seemed that he was not coming back. I was honestly hurt and discouraged. When it appeared that we were finally facing the crux of his distress, he disappeared.

I now had to make sense of why he ceased therapy when everything seemed to be going so well, the alliance seemingly stronger than ever, the exploration of his admission of hating me and his important disclosure had finally been put into words. The confronting yet essential need for self-reflection and supervision was more urgent than ever, and the idea of presenting a reflective paper based on this case was born.

Reflections on the sudden ending

After several years of therapy, this abrupt ending had quite an unexpected impact on me despite the warning by Shedler that 'a person who struggles with anger and hostility may struggle with anger towards the therapist'[18(p. 99)]. It had taken years to develop what I had sensed as a meaningful and collaborative relationship with Sam and create a space where he could confront his fears. The sudden cessation of therapy was jarring, and I felt that I had failed as a therapist. I felt lost and unsure of myself. I began to question the whole therapeutic experience. How do I deal with the loss of this important relationship? How do I deal with not knowing what happened to Sam? How do I make sense of the abrupt ending of the therapy? Had I used the 'right' trauma therapy approach with Sam? With these questions in mind, I began to reflect on the importance of owning the aspects of being a therapist; balancing the professional relationship, maintaining the therapeutic frame, engaging and listening with Freudian-inspired 'evenly hovering attention'. After wrestling with these thoughts and using supervision, I saw our work a little more objectively.

I examined my own fantasies about therapy and working with Sam. I recognised how much I liked him and looked forward to our sessions. I recognised how much I had trusted the therapeutic space to help him face the painful memories.

I reflected on how the sheer vastness of unnamed emotions and conflicts that had contributed to so much pain was frightening for both of us. I felt helpless and wondered if I had really been able to sit with and bear witness to the conflict and guilt he felt; if I had truly come across as genuine and authentic. I was reminded of another patient whom I had also worked with for some years, telling me I spoke to him honestly and 'not out of the back of some textbook'. Had I really empathised enough with Sam?

Though he had told me on several occasions how difficult it was for him to be in therapy with me, he *had* started to notice improvements in his day to day life, and he continued to attend appointments regularly. He no longer had intense outbursts of anger, and he described feeling less nauseous when he talked about his deployment experiences in session. By his own accounts, he was getting better and was slowly facing the gnawing pain of guilt and shame. It was hard for me to be left contemplating his pain. I realised how much I needed to be able to 'bookend' my work. I reflected on how sitting with the unknown mirrored his excruciating pain of not knowing what had happened to the man whom he had shot.

Supervision, with a much-respected mentor, was now more vital than ever if I was to find some personal closure to this case. Unfortunately, I will likely never know what happened to Sam, but I have been able to accommodate this experience within the larger frame of my therapy work and use it as a valuable learning tool in teaching and supervising my students.

The abrupt and unexplained dropout from seemingly successful therapy by the client can be disturbing and threatening to the professional adequacy of the therapist. Attempts to account for what looks like a sudden failure of therapy can obviously go two ways—attributing cause to the client or the therapist. Reflections on self-doubt and self-blame can provide a usable foundation for improving one's capacity as a therapist. The use of supervision is also vital in processing experiences from within the therapy hour that have inevitably left their mark.

The unconscious aspects of combat trauma

The years I spent with Sam allowed me to recognise the absolute importance of allocating time for the unconscious experience of the trauma to emerge within the therapeutic relationship. I believed that at the beginning of therapy, he did not know what was truly causing his distress. From a psychodynamic perspective, I considered him to be repressing unconscious conflicts and emotions (rather than just avoiding them consciously). What emerged was deeply personal and had not been accessible to him for several years. The therapeutic relationship and frame had been built patiently over time, so we could hold his revelation of hating me between us without trying to restructure, react defensively and simply see it as an irrational thought or emotion to be explained away.

Had I used the more manualised and cognitive trauma interventions with homework tasks and behavioural experiments, I doubt we would have truly gotten to the core of his pain in the way he did. While Sam could recount the bomb blasts and other firefights with relative ease (appropriate fodder for traditional cognitive-based trauma work as he had ready conscious access to these events), it was the agony he experienced over the uncertainty of what had happened to that man he fired at that really caused the most pain and guilt. Carr,[21] referring to Stolorow,[25] locates the source of trauma in the painful emotions associated *to* the event rather than in the events themselves. This was pain in the form of shame that needed to be shared only after the alliance had solidified, taking some years to do so.

I hypothesised that Sam's conflicts of shame and guilt over the apparent death of a young insurgent were also unconscious for much of the initial part of therapy. The agitation, nausea, low moods, angry lashing out and anxiety were all likely perpetuated by the deep-seated conflict he felt over the taking of life.

When working with combat veterans, it is vital to maintain curiosity and awareness of potentially underlying unconscious conflicts that perpetuate symptoms and behaviours. It can take quite some time for these to emerge, and the therapeutic relationship forms the vessel in which these can be shared, discussed and worked through, hopefully resulting in symptom reduction and an increased sense of wellbeing.

Broader issues in working with combat trauma

Cases concerning veterans such as Sam and similar PTSD sufferers[21] suggest that psychodynamic psychotherapy can be considered a viable option available to therapists who treat combat trauma

veterans. While it was unfortunate that Sam did drop out of therapy, he *had* made significant strides in being able to confront and begin to process the traumas he experienced. His self-reported improvement in day to day life was a testament to that. The provision of a safe space to explore distressing experiences and emotions *in the context of a therapeutic relationship* is one of the core tenets of psychodynamic approaches.

That being said, psychodynamic therapy theory and techniques can certainly be integrated with more cognitively based trauma therapies such as prolonged exposure, CPT and EMDR. An appreciation for the power of the unconscious and the importance of a strong therapeutic alliance does not stop one from using these standard trauma therapies; it may very well *enhance* the work and outcomes.

What is also important is the recognition that good and effective therapy can take a long time, often far longer than what agencies and manuals suggest.[26] Clients may present on and off to agencies over many years as they struggle to deal with their distress and underlying conflicts. Being able to provide long-term stable therapy is vital for working with this population, given the complexity of their trauma and unconscious emotions/conflicts that drive distress.

Finally, therapists working in the therapeutic relationship with combat trauma survivors can expect to be affected by the content of the therapy and the perceived responses and behaviour of the client. I suggest the anticipation of, and inevitable experience of this, provides an opportunity for the undertaking of ongoing reflective supervision so that the therapist too can experience a safe and non-judgemental space to articulate, explore and process their experiences (both conscious and unconscious) of the client and therapy. Being able to practice effective 'self-care' as a therapist is imperative when working with traumatised individuals. Agencies would be well advised to support and facilitate access to high-quality and ongoing supervision with appropriate supervisors to provide support to therapists in this area.

Summary and conclusion

Case studies such as the one discussed above reveal several issues pertinent to working with combat veterans within a psychodynamic framework. Not all veterans need to or will be able to engage in such intensive therapy work. Therapists need to be able to ascertain which approach will be most suitable for their client based on a thorough assessment and awareness of the client's personality structure and trauma background. However, even having done this, therapists must also be aware that these clients may continue to struggle with unconscious conflicts, anxiety, depression, shame and guilt and ultimately *still* drop out of therapy. Unresolved endings are an unfortunate yet intrinsic part of working with trauma in these settings.

Therapists should also be prepared for the intensity of the work within the therapeutic relationship, aware of the limits of this relationship and their capacity to reflect openly on the healing function of the relationship. Experiences such as sudden endings or revelations of hate, guilt or shame can be held and explored with the client and reflected upon in supervision. The availability of a safe and stable supervision/reflective space and supervisor is also vitally important when working with this population. It is hoped that this case will further encourage reflection and discussion on trauma, psychotherapy and working within the combat veteran population and that agencies that provide therapy and support to this population consider implementing and maintaining appropriate high-quality supervision for clinicians.

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