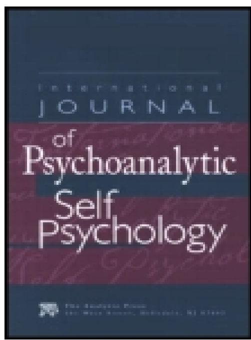

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Russell Bryant Carr M.D.

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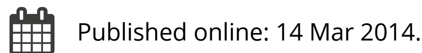
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Authentic Solicitude: What the Madness of Combat Can Teach Us About Authentically Being-With Our Patients

Russell Bryant Carr, M.D.

The author's work with combat veterans who have participated in horrific violence has led him to re-examine therapeutic action and the role of empathy. Authentic solicitude, as Robert Stolorow describes in *World, Affectivity, Trauma*, becomes central to forming a relational home for processing and integrating traumatic emotional experiences. The author argues that we must use empathy as a tool to find our shared humanity with our patients, the heart of which is finitude. The author also describes some forms of inauthentic Being-towards-death that might serve as unconscious defensive functions for both patients and therapists when facing finitude. He demonstrates how he applies these ideas to understand his reactions when working with patients who have participated in actions that dehumanize others. A stance focused on authentic solicitude with our patients can shift psychoanalysis towards providing a dialogic, relational home for trauma.

Keywords: authentic solicitude; combat post traumatic stress disorder; empathy; Heidegger; intersubjectivity theory; phenomenology; relational home; trauma

The Problem: Hearing the Unspeakable

As a psychiatrist in the U.S. military, I have heard many horrific descriptions of combat from the wars in Iraq and Afghanistan. When I present cases of combat-related trauma to non-military colleagues, I often notice that some therapists cannot tolerate the accounts of combat. I think it's the killing and ugliness my patients

Russell Bryant Carr, M.D., is an active duty Navy psychiatrist and the Chief of Psychiatry at the Walter Reed National Military Medical Center. He completed psychoanalytic training at the Institute of Contemporary Psychotherapy and Psychoanalysis in Washington, DC.

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, the Department of the Army, the Uniformed Services University of the Health Sciences, the Department of Defense, or the United States government.

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report doing that is difficult for them to hear. They tell me that my patients "should have known better" or "he is not a very nice guy." Some listeners become angry toward my patients, sometimes openly condemning them. These therapists and analysts, all very skilled in their work with patients, have immediate visceral responses. They didn't want to hear, or they wanted to condemn instead of help, the soldier as he described what he did. When they express their reactions, they often switch terms I used, such as "killed," to "murdered." These therapists are repulsed, and they should be. Combat is ugly. It is a fight for survival. As one of my patients once said, "There is nothing special or good about it. It is people killing people." I agree with anyone who recoils from it. I have too. But then how do we help the combat veteran sitting in front of us, or any patient who has done something we can't tolerate? How do we not look away? In my own more grandiose fantasies, or what I now call my resurrective fantasies, I thought I already knew the answers: Just strive to remain empathic. But I soon found myself face to face with a patient's experience that was unbearable to me, where my empathic stance collapsed and I was left alone in my vulnerability.

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Captain A

I was treating a soldier with severe post traumatic stress disorder, whom I shall call Captain A. I encouraged him to share his experiences with me. I helped him feel that maybe I could understand them and provide a relational home for him, or what I understood at the time as an empathetic stance. I had assumed just such an empathic stance many times before with combat veterans. It had begun to feel routine, but that sense of routineness of the work was a way for me to hide from myself that I did not want to be fully engaged with combat trauma. It was wearing on me. I felt vulnerable and felt I could not show it. I felt my only recourse was to remain empathic. With this patient, I soon found myself hearing atrocities I had never encountered before. At that point, I became all too engaged. I was trapped in my empathic stance and wanted to end it. I didn't want to hear any more of what Captain A had done or felt. I found myself disgusted that he could do such things, and that he did not at the time feel that they were wrong. To make matters worse, he added that he enjoyed the killing, and described how he missed it. I couldn't go there with him. I couldn't hear the graphic details, even as he told them to me. Captain A described ways he had killed insurgents and others in combat in Iraq to make it more painful. His strategy was to play on the sympathy of other Iraqis and draw them out into the open to do the same to them. He wanted to "show them" after seeing several of his buddies killed and enduring several days of attacks. I could feel his never-ending accounts of killing after killing shattering what was left of my sense of a just, sane world. I couldn't bear hearing anything further in those moments. I could not understand such madness. I wanted to remain with him but could not. I felt a horrible bind. I froze and became numb. I disengaged and disappeared from our dialogue. Captain A continued on without me for several more moments, almost seeming to brag about what he had done. I looked for an escape, and luckily for me, I realized our session time was coming to an end. I spent the rest of that day after Captain A left feeling numb and uneasy. My ability to listen and tolerate horrific experiences had been surpassed. I found

myself, humbly, forced to recognize that I was in the same position as both my patients and my colleagues: Shamed like my patients at failing to bear the traumatic experiences of combat and, like my colleagues, turning away from its horrors. But my passion for working with traumatized combat veterans quickly returned after this experience, and I did not want to abandon CPT A. I suspected that I had left him alone in his hell of a traumatized emotional world. At least I hoped that I had not outwardly rejected him. I dreaded his return to my office in a few days, because I saw no other way than to try to remain empathic. How could I tolerate further sharing with him such horrific experiences, and how could I tolerate the changes I feared it would bring in me? Did he pick up that I could not listen to what he had to say, that I had failed to provide a relational home for him? If I continued on this path of a forced empathic stance regardless of its impact on me, I envisioned myself becoming more traumatized during our future appointments.

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Thesis: What Working With Combat Veterans Might Teach Us

Combat veterans are an unusual opportunity for us to examine how we relate to our patients. As participants in combat, their experiences frequently combine aspects of both victims and perpetrators of violence. They have survived a dehumanizing context. Hearing their own perspectives on violence that combat veterans have brought to bear on other human beings has helped me realize that they, just like victims of violence, have lost a sense of being human, of being connected with the world. Their sense of self has been shattered. They have survived combat, and that survival has often meant that others have died, whether fellow soldiers, enemies, or civilians. Once they return home, we welcome them. But then we might hear what horrors they have done in combat and push them away. Like monsters we imagine such as rapists or murderers, we fail to see our common humanity with them. By saying they should have known better or by "going numb" in session with them, we sacrifice our mutual humanity to our need to feel invulnerable. We turn away to avoid overwhelming feelings such as fear and guilt.

I have come to the conclusion that we need to relentlessly strive for the humanness in both of our experiences, to relate to them in a way that frees both them and us, all of us, from perpetuating the consequences of traumatic emotional experiences, such as reducing the world to dyads of victim and perpetrator. These dyadic words have no place in therapy in my opinion and obstruct us from understanding each other. Robert Stolorow has laid the groundwork for such an approach in his most recent book *World, Affectivity, Trauma* (2011). His description of authentic solicitude helps me to find common ground and thus provide a relational home to my patients whose actions, paradoxically, repulse me. He has shown me that a relational home must be dialogic and thus has freed me not to hide my reactions to my patients' experiences. His ideas require that we not turn away and dehumanize them, even if we decide we cannot work with them and refer them to someone else. But if we hope to work with them, we cannot remain static, routine,

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and detached, and thus not human. Engagement with them includes acknowledging our limits of understanding with them in order to develop a new understanding of their experiences together. We must be vulnerable with them.

By applying Stolorow's ideas on authentic solicitude to my work with combat veterans, I have rethought some of the fundamental bases of our work, such as therapeutic action and the role of empathy. As early as 1959, Kohut described introspection and empathy as modes of observation that are essential to psychoanalysis (Kohut, 1959). He felt that we cannot understand human experience, and thus cannot perform psychoanalysis, without using them as basic tools. Empathy is a tool for us to get a sense of the patient's experience, and he espoused that we scientifically understand the data gathered with these modes of observation through prevailing psychoanalytic theories. But Stolorow points to an additional framework for understanding this data: We must also seek common ground through our use of empathic introspection with our own experiences of being human (Stolorow, 2007). I now believe that we must use empathy as a tool to find our shared humanity with our patients, the heart of which is finitude. Therapeutic action requires more than empathy. We must show our human face to our patients, especially patients who have suffered the dehumanization of violence. Such a stance focused in sharing vulnerability, or authentic existence, with any patient, can be difficult to tolerate. We must expose our vulnerability to them and not keep them at a safe distance. Being with people who in other contexts have been perpetrators or participants in, or even victims of, violence can make the most sympathetic therapists among us feel queasy. Hearing and feeling the dehumanization might repulse and sadden us. We must acknowledge that reaction as part of our common ground, our shared humanity.

At the heart of this shared humanity is finitude, comprised of both mortality and limits. It is our common ground. As we share our finitude together, we might find that both of us can live more authentically without denial or disavowal or otherwise feeling that our emotional states are unwelcome. This form of Being-with, or sharing, is what Stolorow calls authentic solicitude. It is dialogic. I hope to explain how this idea and several related ones apply to addressing traumatic emotional states, such as combat-related trauma, from which all of us at times struggle not to turn away. These ideas might redefine our understanding of our own subjectivity's role in therapeutic action. Authentic solicitude brings our own subjectivity into the treatment much more fully than an empathic stance alone does. We must recognize our interconnectedness so that our patients and we might exist together authentically. This intersubjective approach, based on finding the common humanity in the midst of the dehumanization inherent in violence, necessitates two people acknowledging their mutual existential vulnerability, or kinship-in-finitude (Stolorow, 2011). One might even call it an attitude of love. This approach derives largely from Stolorow's more recent book *World, Affectivity, Trauma*, based on his extension of Heidegger's ideas Being-with and authentic solicitude. I believe his ideas can guide us to an ethic that enriches our intersubjective understanding of traumatic emotional experiences, regardless of our patients' roles in the violence and dehumanization they describe to us.

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Applying Intersubjectivity Theory and Authentic Solicitude to Bearing Traumatic Emotional Experiences

In *World, Affectivity, Trauma*, Stolorow extends his existential, Post-Cartesian understanding of trauma that he described in *Trauma and Human Existence* (2007). In particular, Chapters Six, Seven, and Eight hold important understanding for my questions. There, Stolorow describes a relational way of Being-with our patients as human beings in a shared world that has ethical implications for our work and helps us authentically be with patients with whom we feel we can work. His philosophical reasoning gives credence to the belief that we are all bound to one another in our finite existence. Mortality is a common ground for all of us. Stolorow refers to mortality as finitude, but this word encompasses more than all of our inevitable deaths. It also includes our limits as mortal beings. For instance, we can all only run so fast, but some faster than others. Some cannot run at all. This is a concrete example of both the universal nature of our limits and also how these limits manifest themselves uniquely among us. Both our universal inevitable deaths and our universal status of having unique limits are common grounds for all of us. Unfortunately, evasive, or inauthentic, ways of bearing this finitude create many of the problems all of us face in the world, including dehumanization and self-destructive tendencies. In this view, much pathology is based in inauthentic existence and develops when there is no relational home for overwhelming emotional states.

To counter inauthentic existence, our patients need us to offer authentic solicitude for them, which Stolorow (2011) defines as a way "to attune to and be a relational home for" (p. 77). This entails striving to help them understand their experiences of the world, including their finitude, in order to help them to bear, process, and integrate traumatic emotional experiences into a cohesive sense of authentic self (Stolorow, 2007; Stolorow 2011). But we cannot authentically Be-with, or provide a relational home, through empathy or other modes of observation alone. We must acknowledge the shared humanity of both of us as we sit together in the consulting room. Stolorow expands some ideas of Martin Heidegger so we can better understand why we as therapists must be authentic or non-evasive about our finitude with our patients as our common human experience so that they can be authentic as well.

In his exploration of Martin Heidegger's ideas on Being-with other human beings, which Heidegger himself called Mitsein, Stolorow describes and expands authentic resoluteness, authentic Being-towards-death, and authentic solicitude to describe how we can authentically Be-with another person. Stolorow also coins the term kinship-in-finitude to help connect Heidegger's terms with the therapeutic work of providing a relational home to others. These terms describe our relationships to the world, our shared place in it, how we can respond to each other by acknowledging our mortality and other limits, and the associated anxiety in realizing these limits.

Stolorow's term kinship-in-finitude is a synthesis of two ideas that he developed in *Trauma and Human Existence* (2007). He defines this term in Chapter Six of *World, Affectivity, Trauma* (2011). One of the ideas from *Trauma and Human Existence* is that all emotional life, including traumatic emotional experiences, exists only in context.

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Emotions and their contexts are inseparable. Thus, we must know context in order to understand someone's experiences of self and world. The second idea from *Trauma and Human Existence* replaces Kohut's conceptualization of twinship. Stolorow argues that the need for twinship is not inherent but only appears so because of the universal nature of trauma inherent in mortal existence. Twinship is thus a fundamental way of dealing with traumatic emotional experiences. Twinship in this formulation is a longing for understanding and kinship in the face of ubiquitous traumatic experiences. Sharing them in order to process them is fundamental because we are social beings and our emotions are so embedded in our contexts. Stolorow argues that our very sense of being comes from putting words to our experience with others around us, or the surround. From this understanding, experiences become traumatic when the associated emotions cannot be processed or integrated with the surround, for example, put words to them with another human being. This shared predicament, what Stolorow calls kinship-in-finitude, gives us the opportunity, and also requires us, to find understanding from other people if we hope to bear our specific traumatic experiences. Sharing our kinship-in-finitude, is what Stolorow calls authentic solicitude.

In addition to coining the term kinship-in-finitude, Stolorow expands Heidegger's authentic solicitude to explain the relational nature of finitude. Authentic solicitude describes how we can relate to each other as human beings mutually caught in limits, or kinship-in-finitude. It requires a person to have resoluteness towards his or her own finitude in order for it to emerge in a relationship. Heidegger describes authentic resoluteness, or authentic Being-one's-self, as how one relates to one's place in the world (Heidegger, 1927). There is a particular emphasis in Stolorow's expansion of this term on how one acknowledges an aspect of one's finitude or place in the world: Being-towards-death. Being-towards-death is how we relate to mortality. Because we are fundamentally relational beings, it includes not only our mortality but also the mortality of those we know. Stolorow describes in *Trauma and Human Existence* (2007) how death is fundamentally relational. Death will come to all of us, and we only know about it through the loss of those around us. So a fundamental part of Being-towards-death is Being-towards-loss. Both our own mortality and the inevitable death of those we know are fundamental parts of human existence. As one acknowledges these realities, one can feel anxiety and "uncanniness." These feelings, if overwhelming, are the bases of traumatic emotional experiences if not processed with others.

Authentic solicitude requires authentic resoluteness in the face of our finitude. Resoluteness, according to Stolorow (2007), means that we acknowledge our finitude as we feel the "uncanniness" of Being-towards-death and Being-toward-loss, and we base our priorities and decisions upon our fundamental vulnerabilities. Resoluteness is the positive result of being constantly conscious of both our impending death and limits as mortal human beings. Paradoxically, according to Stolorow and Heidegger, we only reach our greatest achievements as human beings when we are conscious of such limits on us. Resoluteness involves learning to acknowledge and exist within the general limits of our mortality and our unique limits as individuals. This resoluteness is a state and requires attunement to it from the surround around us, or a supportive human context, for it to be sustained.

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Being in such an authentic resolute state towards our finitude or vulnerability leads to authentic solicitude toward another human being. Authentic solicitude is a way to connect with another human being within our mutual finitude, a way to elicit such an attitude in another person. We are not turning away, but instead offering our finite, vulnerable face to another human being. It is a mode of listening to and communicating with another person. Authentic solicitude does not lead to the therapist "leaping in" and telling the patient what to do, and also is not idle chatter or unfounded positive support (Stolorow, 2011, p. 74). It is based on the underlying recognition that we all have limits and that we will all die at undetermined times. Heidegger and Stolorow argue that this form of listening and communicating will evoke in others their own "ownmost possibilities" (Stolorow, 2011, p. 75) in light of their own finitude. Thus, it leads to the therapist "leaping ahead" of the patient, in the sense of aligning the therapist with the patient's finitude and the limits it places on him or her (Stolorow, 2011, p. 74). Not only are the patient's "ownmost possibilities" aroused with authentic solicitude, but also the patient's existential anxiety is provoked as well. In order to help a patient bear both finitude and his or her ownmost possibilities, we provide a relational home by exposing our own finitude. We bear our mutual finitude together. I'll quote Stolorow here:

> When we exist authentically, we disclose our Being-toward-death, and we disclose the finitude of our existence in our anxiety. Authentic solicitude requires that we have the ability to comport ourselves authentically toward our finitude and to bear the anxiety of such comportment, because only then are we able to understandingly Be-with—to attune to and be a relational home for—the other's anxiety, as we help free him or her for his or her ownmost and uttermost possibilities of Being. Furthermore, it is the other's authentic solicitude toward us, and the other's attunement to and holding of our existential anxiety that helps us to exist authentically. (p. 77)

In other words, once we have provoked such acknowledgement of finitude in a patient through solicitude, we must authentically "Be-with" that patient in our mutual resoluteness toward finitude so they too do not attempt to evade authentic Being-towards-death. We support each other in our shared vulnerability and the accompanying anxiety. If one of us is not authentically engaged in this way with our own vulnerability, it is easy to evade finitude, not provide a relational home, and remain in a traumatized, dehumanized state.

An example of authentic solicitude might demonstrate how sharing vulnerability can impact a therapeutic relationship that has become mutually toxic. Several years ago, I treated a senior enlisted non-commissioned officer while I was the medical director of a military hospital's psychiatric ward. He had been diagnosed in the past year with chronic back pain, alcohol dependence, depression, and a narcissistic personality disorder. He had been stationed on several different ships during his career, but never saw combat. Several other staff at the hospital either feared or hated him. He was known for being very demanding for pain medications. Emergency department staff frequently called hospital security as soon as they saw him getting checked into the emergency room to be seen

for pain. He was known for threatening to harm staff, and at least once threw chairs against a wall in a rage while getting treatment. On several occasions, I had attempted to treat him on our psychiatric ward following suicide attempts by overdose. On the ward, he would frequently become belligerent, uncooperative, and demanding. He would also deny that he had attempted suicide. I had attempted to coerce him into good behavior on the ward in the past by holding over him that we would charge him with assaulting staff, but this only contained his behavior. It did not address his repeated overdoses.

I then saw him on our ward following a third suicide attempt. The nursing staff had told me when I arrived to the ward that morning that he was already becoming belligerent after having only arrived to the floor from a medical ward in the hospital the night before. It was estimated that he took between fifty to one hundred pills in this recent overdose and was only alive because someone found him in his room unconscious. I was determined to reach him, both to understand him and to try to help him. I sat down with him with no one else in the room: No nursing staff or residents. Nursing staff still watched us through a window for my safety. The patient and I talked for several minutes at first about why he was even on a psychiatric ward. He felt that he did not need to be there because he was not suicidal. He denied he had overdosed. I told him that we needed to discuss how to deal with his suicidal thoughts. This was standard material for us on the psychiatric ward. But then our conversation changed:

> *Patient:* That is the only fucking thing you doctors want to talk about: My suicidal thoughts. YOU ARE NOT LISTENING TO ME!!! (*Shouting*). THIS IS ABOUT MY PAIN!!! DO SOMETHING ABOUT THAT!!!!
>
> *Me*: Maybe I don't talk about your pain because I feel helpless against it too. Your pain is overwhelming to me. I don't know what to do about it, so I fall back on what I know.

This was a spontaneous, authentic response from me. I did something more than understand with psychoanalytic theories what data I had gained about him through empathy and introspection. My response showed my vulnerability in trying to help him. I, too, felt in the moment that I was helpless against his overwhelming pain. It was beyond my skills and understanding. I also acknowledged how much pain he must be in. Simply put, I embraced both his anger and our vulnerability. I was only starting to understand at the time how frequently vulnerability drove his anger. We shared a moment of kinship-in-finitude. This sharing is based in authentic solicitude. Although I felt at the time that I had shared a moment of connection with Mr. B, I did not know what to call the shift in my approach to him that started at that moment. I just knew it worked with him. He stopped shouting at me, and never did again. I no longer felt anxious or angry with him. We had a lengthy discussion about his sense of frustration and helplessness about his pain, and his perception that doctors did not believe he was in pain or only saw him as a monster or a drug seeker. We had formed a connection. We saw each other as human. I no longer entered into the dyad with him of drug seeker and reluctant drug supplier.

In the moment with Mr. B, I acknowledged my limits to address his pain and my uncanniness in the face of it and his possible suicide. I also remained engaged with the

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problem and sought ways to solve it within my limits, thus remaining resolute in my Being-towards-loss. I did not continue to avoid or evade addressing my sense of vulnerability in that moment with further anger or attempts to control him, which would have been inauthentic. I shared my finitude with him and thereby elicited him to do the same. I would argue that his yelling at me in the moment, and possibly his violence in the past, were inauthentic, restorative attempts to deal with overwhelming vulnerability that his surround did not acknowledge. Before I put words to my vulnerability in dealing with his pain, he was literally yelling at me in anger and desperation because I was not acknowledging our common humanity. We were dehumanizing each other, and therefore neither of us was free and authentic. We both attempted to coerce each other through inauthentic ways. There is a restorative, or resurrective, quality in these inauthentic attempts to dampen vulnerability through coercion and verbal and physical violence.

After that conversation during his third hospitalization, Mr. B would frequently ask for me to help him with problems, particularly when he felt other physicians did not understand him. I rarely give out my work blackberry number to patients, but I gave it to him. I told him that I would be greatly saddened if he committed suicide and told him to call me any time on that number for emergencies instead of killing himself. He did not abuse my offer. He called me only once, a month or so later on a Friday night, upset and saying that he did not feel he was safe to be alone. He agreed to be hospitalized, and the staff said he was very cooperative. This was a brief hospitalization, and I believe one of his last for suicidality. Shortly after that, he agreed to prolonged residential treatment at a center for pain, substance abuse, and "psychiatric disorders," which helped him tremendously. I feel our connection, based on both of us acknowledging our kinship-in-finitude, kept him alive through this very rough time in his life.

Because our emotions are contextual, we need those around us to acknowledge their own finitude in order for us to live in our own finitude as well. When two people in the room are acknowledging and sharing their mutual status in the world as mortal, limited beings and the anxiety that accompanies this recognition, it changes their relationship. It forces them to acknowledge each other's "existential vulnerability and pain." We humanize each other. With this acknowledgement of our shared predicament in the world as finite beings comes a kinship, and is the basis of what Stolorow (2007) has described previously as "emotional kinship-in-the-same-darkness" of trauma (p. 49). This kinship in our shared finitude leads all of us to recognize that we are interconnected with each other. Authentically recognizing our mutual finitude, our shared humanness, obligates us to bearing together our fears and vulnerability as we go together towards death. The other is human like us, and so we cannot look away. Because our emotional life and sense of being is embedded in the context of those around us, our sense of self is interconnected with this other in our world. We are interconnected, and can only live an authentic life by acknowledging these connections through our mutual limits and mortality. Otherwise, if we dehumanize the other, we dehumanize ourselves due to denying that fundamental interconnectedness. Then we find ourselves caught in a false, binary relationship of predator-prey, owner-slave, perpetrator-victim. Kinship-in-finitude also obligates us to recognize and bear together our differences. The qualities of our limits are unique to us. They make up our individual qualities, how we know each other. In the

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sense of divulging the shared and unique qualities of our finitude, authentic solicitude obligates us to care for the other as a unique human being, and can form the basis of friendship, love, or a psychoanalytic attitude or ethic.

I'll quote another lengthy passage here from Stolorow's *World, Affectivity, Trauma* that I think provides a good summary of authentic solicitude:

> "Therefore, according to my claims about the contextuality of emotional life, we must Be-with—that is, attune to—the other's existential anxiety and other painful affect states disclosive of his or her finitude, thereby providing these feelings with a relational home in which they can be held, so that he or she can seize upon his or her ownmost possibilities in the face of them. Is not such attunement to the other's emotional pain a central component of friendship or love? Authentic solicitude can indeed be shown to entail one of the constitutive dimensions of deep human bonding, in which we value the alterity of the other as it is manifested in his or her own distinctive affectivity; it "lets the other be as Other" (Raffoul, 2002, p. 217). (p. 75)

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Defensive, Inauthentic Being-Towards-Death

Sharing our mutual finitude is the authentic, intersubjective way inherent in our contextualized existence through which we can process and bear the ubiquitous traumas of life. We will never be the same as before a traumatic experience. But we can, hopefully, integrate it into our sense of ourselves by processing it with other finite human beings and find new priorities and focus in our lives. There are also inauthentic ways of dealing with traumatic experiences. Without calling them inauthentic Being-towards-death as Stolorow would, we are all familiar with these phenomena as mental health care providers. All of them are ways to look away from or counter vulnerability. Both patients and therapists might use inauthentic ways of dealing with mortality and limits. With alcohol, for instance, some of us wash away our vulnerability and limits from our minds. Others deny what we cannot tolerate, such as a person refusing to acknowledge when a spouse has had an affair. Others, the ones I want to focus briefly on here, we employ to serve an unconscious restorative or resurrective function. They are attempts to restore a prior sense of self or community that has been lost after a devastating, traumatic experience. They can be the attempts to resurrect a sense of self that existed previously but overwhelming traumatic experiences and vulnerability shattered. When groups adopt these resurrective approaches to trauma as a belief or policy, Stolorow calls these resurrective ideologies (Stolorow 2009).

Combat is an extreme, concentrated example of the ubiquitous nature of trauma. Everyone is dehumanized in combat. Traumatized combat veterans might have survived the intense Being-towards-death of combat through evasive, inauthentic means. Soldiers who feel chronically vulnerable, just like Captain A, might resort to cruel dehumanization of their enemies in order to counter the vulnerability. They might "play God" in killing others in order to no longer feel so helpless, reveling in the reality of survival through an illusion of omnipotence instead of feeling and processing the anxiety of their

own mortality and the loss of fellow soldiers. People, such as soldiers in prolonged exposure to their own vulnerabilities without a sense of bearing it with others, might adopt resurrective ideologies to return to a sense of control they feel is missing. As part of such an ideology, perhaps they have called the people they felt they had to kill evil or worthless or subhuman. Perhaps they told themselves that their own actions towards these subhuman beings were part of a greater good. It helped them be ruthless and survive. It covered or obliterated their own fears and Being-towards-death or Being-towards-loss, the sense of isolation in their vulnerability, and the overwhelming feelings associated with killing other humans just like them. After they have survived and they are out of that context or the threat has passed, what they had concealed from themselves starts to return. It is similar to manic euphoria or a drug high receding. After the grandiosity and sense of power that had obliterated any vulnerability are gone, both personal vulnerability and the recognition of what they did to fellow human beings emerge. The realization of having killed other human beings can lead to overwhelming guilt and shame. A combat veteran once described this well to me: “I don’t deserve to be alive because of what I did. I killed people just like me: Brothers, sons, fathers.”

Therapists can also react inauthentically when faced with the overwhelming feelings of extreme trauma, such as combat. When a combat veteran comes to us for treatment and the carnage of war appears before us, we might not be able to relate to the patient’s experience and might recoil. We feel vulnerable, overwhelmed, and retreat. We might say to ourselves, “He should have known better than to kill all those people.” The fear and vulnerability of the veteran is missed. The patient is dehumanized as the therapist inauthentically implies that violent experience such as combat is not a human experience. The therapist dissociates violence out of human history, as if it has not always and continues to be there. There is no human connection, and the patient and therapist are alone together in their inauthentic states. For both people in the room, there is no recognition of kinship-in-finitude or authentic Being-towards-death. Neither supports authentic solicitude in the other. The veteran’s sense that his actions were not normal (in the sense of being a common human experience), not human, and perhaps evil is reinforced as he is left alone with them. He may be overcome with the shame of his apparent singularity and rely even more heavily on the resurrective function of dehumanizing others. He may become even more racist or threatening violence on others he learned long ago to dehumanize, even before his combat experience, such as women. The therapist may feel more vulnerable, numb and traumatized. As both feel increasingly disconnected, the patient may express even more fondness for the times when he was killing others.

My interactions with Captain A as he told me about his combat experience is a good example of such a failure of the patient and therapist to authentically Be-with each other in authentic solicitude. Even though I am quite familiar with and connected to the wars in Iraq and Afghanistan, I had trouble hearing his actions in combat. I was not authentic with him. I did not feel fully engaged in my work with him from the outset, meaning that perhaps I was not in a state of authentic Being-towards-death even as I began with him. My work with others, solely focusing on an empathic stance and not acknowledging my reactions to combat, had worn on me. I wanted to keep my distance emotionally.

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But I soon found myself thrown into an overwhelming state as all the death and carnage emerged before me. I felt I could not tolerate and possibly share my vulnerability and limits of hearing his story. Instead of acknowledging them to both of us, my inauthentic reaction was to sit quietly, to stop interacting, to fake that I was still with him. I think he picked up on my lack of authentic solicitude. Instead of a human, vulnerable face from me as a fellow human being overwhelmed by combat, he received a silent, dehumanized inauthentic person. I might as well have been poster board, or perhaps my denial of kinship-in-finitude was even worse than being poster board. Because he did not receive a human connection that could help him bear his guilt and shame, CPT A clung to his resurrective grandiosity of killing Iraqi's "to show them" how powerful he needed to feel in the face of his own possible death at any moment. By not acknowledging my own limits in bearing the horror of what he described, I did not provide a relational home to bear his overwhelming sense of vulnerability and anxiety. Perhaps through his story, he was also trying to show me just how vulnerable he felt.

Conclusion: The Dialogic Nature of Authentic Solicitude

What are some of the implications of striving for authentic solicitude with patients? Paradoxically, authentic existence actually frees us from the imprisoning notion that we must work equally well with all patients who come to us regardless of the source of their suffering. The obligation remains to be authentic and honest with this stranger we have invited to be with us as a therapist or analyst. But we must recognize when feelings and judgments we have about specific behaviors or beliefs, whether they are drug addiction, violence in combat, racism, verbal assaultiveness, or committing specific crimes, interfere with our ability to relate to our patients. Otherwise, we risk dehumanizing them; just as they might describe to us the harm they did to others, or how they were dehumanized and harmed themselves. We might then tell them they do not need therapy, or that they are untreatable. We enact with them the separateness and singularity they already feel and have experienced in those moments of unbearable emotional trauma. Even acknowledging we cannot work with a particular person is better than going numb and pretending that we are still trying to bear emotions with them. Perhaps there is relief in showing the limits of our ability to comprehend the horror of their experiences. When there are sources of suffering in our patients we cannot tolerate, whether discovered in the initial appointment or later, we should compassionately acknowledge it while helping him or her find someone who can bear the work. Otherwise, we, as Donna Orange and Levinas maintain, kill them by looking away (Orange, 2011).

Stolorow's descriptions of authentic solicitude have shown me how we are obligated to not turn away. Our own authentic resoluteness and Being-toward-death form the basis for authentic solicitude: A way to authentically Be-with our patients. Turning away denies shared humanness in the face of our shared finitude. It also makes our existence in that moment inauthentic. We deny our shared kinship as finite beings. By turning away, we also deny our finitude, our limits in relating and understanding. Neither of us can then attain our ownmost possibilities in the face of our mutual limits if neither of us can acknowledge those limits. Showing our own vulnerabilities and limits in those moments maintains a human relatedness.

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Authentic solicitude as a basis for therapeutic action acknowledges and emphasizes the bi-directional nature of psychoanalysis. It remains asymmetrical and patient-centered, but it requires a willingness to explore and understand our own feelings of vulnerability and ability to dehumanize others. The intersubjective key to developing authentic solicitude with another person lies in examining the vulnerability that motivates almost all violent or dehumanizing action in us and our patients. It is important to recognize the vulnerabilities that necessitate resurrective or defensive actions for you and your patient. Recognize the sense of annihilation, either actual or anticipated, that often underlies the need for defensiveness affect regulation. Strive to connect with your patient in mutual vulnerability or finitude, cultivating a sense that it is OK to be vulnerable now in the consulting room for each of you. Be human with them by acknowledging the vulnerability, guilt, and shame felt about vulnerability. Help them integrate it into an acceptable sense of who we are. With such acknowledged kinship-in-finitude, both of you can develop a better sense of cohesiveness. Both can recognize and then bear in a relational home the overwhelming responses to finitude that otherwise might lead to inauthentic reactions to vulnerability.

Besides freeing us from an obligation to work with all patients, authentically Being-with our patients might also paradoxically enable us to tolerate working with a wider range or depth of suffering. A shift from focusing on an empathic stance to a stance of authentic solicitude and kinship-in-finitude with our patients can help reduce our own sense of being overwhelmed and ultimately intolerant of the actions of others. Empathy and introspection are tools, not an ethic and not the bases of therapeutic action. They require solicitude to be effective, which obligates us to embrace our limits in understanding our suffering patient. Authentic solicitude in a psychoanalytic approach creates a more relational, humanistic understanding, and thus more room for our own feelings about our patients. The ideas of Martin Heidegger, as extended by Stolorow, give us not only the obligation, but the means to understand experiences that are far outside of our own. A focus on solicitude includes the effects of being a relational home on the therapist or analyst. It requires us to acknowledge and process our finitude and vulnerability and not evade them with unconscious defensive responses that dehumanize both us and our patients. In that sense, the interaction is mutual, more bi-directional. Authentic existence itself is thus codetermined in an intersubjective field. Our patients and we support each other in our limits and finitude, as we strive to acknowledge them together and be our best as human beings. We need, in addition to striving to understand our patient's experience of the world, to be authentically human and thus acknowledge to ourselves, and to our patients, the limits of our own experiences in the session. Ironically, it might have taken the dehumanization and madness of combat to show me the need for authentic existence and solicitude toward all of our patients.

Sharing Vulnerability With Captain A

I'll close by returning to Captain A: A few weeks after I went numb listening to him, whether or not he could trust me came to the forefront. He has pervasive problems trusting people, but had felt he could trust me in the past. Maybe he picked up more from me than I realized when I had gone numb and shifted away from authentic solicitude

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with him. This time, when he brought up trust, I did not hide my difficulty hearing what he had shared with me. I acknowledged that I too can at times belong to that world that doesn't seem to get him, that is across the chasm separating him from the non-traumatized. But I told him that I would always strive to reach out to him as best I can, that I would not reject him, which was also a large part of the repetitive transference. I told him that I strive to understand the effects of combat, and that I get how his overwhelming guilt and shame have shattered him. I also told him how impressed I was with his attempts to reconnect with people and struggle against his sense of deadness. During that session and several future ones, he opened up more to me. Among other things, we shared together his feelings during the IED blast that led to his medical evacuation from Afghanistan. He had never told me this before, and he said he had not told anyone else how he felt about it. I think he did not feel safe to disclose his vulnerability before. He had to keep his guard up for any sign of continued vulnerability and dehumanization, including with me. He had been feeling too vulnerable, until this authentic human moment with me. It led both of us to abandon the inauthentic image of him as an invulnerable killing machine:

> I just found out that they are giving me another Bronze Star with a V for Valor, my fourth. It is tearing me up. I never told anyone this. It is for my actions after the IED blast that sent me here. . . . Our vehicle had flipped over into a ditch. I crawled out. There were a lot of people hurt and killed. Nothing made sense to me at first. I couldn't figure out what had happened. I walked up the side of the ditch to the road, and that is when it hit me. Oh, we were hit by an IED. I saw the hole in the road. We also started taking fire. That focused me. I saw them running towards us, a couple of Taliban. My rifle was all bent. I yelled down to the truck for a rifle. The driver threw his up to me. The stock was shattered. But it still fired. I dropped them both at 40 meters. They were close. For just a split second I hesitated before I dropped them. I remember that second, and think about it a lot now. I only dropped them because of the other guys behind me. For just a second I thought, "Maybe I should let them capture me. I'm going to hell anyway, why not just let it start now." Now when I think of it, I wish I had.

In the moment of sharing his vulnerability with me, we were vulnerable together, human together. He was no longer a killing machine and I was no longer the invulnerable therapist with no reactions to his experiences. Neither of us resorted to our restorative defenses in the face of our vulnerabilities. We were simply two men trying to make sense together of combat and our human existence.

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Russell Bryant Carr, M.D.
Psychiatry Department, Walter Reed National Military Medical Center
America Building, 6th Fl., 8901 Wisconsin Ave.
Bethesda, MD 20889
301-319-4376
russellcarrmd@gmail.com or Russell.b.carr.mil@health.mil

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TRANSLATIONS OF ABSTRACT

El trabajo del autor con veteranos de guerra que han participado en actos de violencia extrema le ha llevado a re-examinar la acción terapéutica y el papel de la empatía. La auténtica preocupación por el otro, tal como Stolorow la describe en *Mundo, afectividad, trauma*, resulta central para la formación del hogar relacional para procesar e integrar las experiencias emocionales traumáticas. El autor argumenta que tenemos que usar la empatía como instrumento para encontrar la humanidad que compartimos con nuestros pacientes, cuyo corazón es la finitud. El autor también describe alguna de las formas inauténticas del Ser-hacia-la-muerte que pueden estar al servicio de funciones defensivas inconscientes por parte de pacientes y terapeutas cuando afrontan la finitud. El autor muestra cómo aplica estas ideas para entender sus reacciones cuando trabaja con pacientes que han participado en acciones que deshumanizan a los otros. Una posición centrada en la preocupación por nuestros pacientes puede cambiar el psicoanálisis hacia el suministro de un hogar dialógico y relacional para el trauma.

Travailler comme analyste auprès de soldats vétérans ayant commis des atrocités a conduit l'auteur à revoir l'action thérapeutique et le rôle de l'empathie. La sollicitude authentique, telle que décrite par Robert Stolorow dans *World, Affectivity, Trauma,* s'avère centrale dans la formation d'un foyer relationnel où les expériences émotionnelles traumatiques peuvent être èlaborées et intégrées. L'auteur soutient que nous devons utiliser l'empathie pour trouver la part d'humanité commune, dont la finitude est le centre, entre nos patients et nous-mêmes. Il décrit certaines formes inauthentiques d' «Être-vers-la-mort» susceptibles d'alimenter des défenses inconscientes chez le patient ou le thérapeute confrontés à la finitude. Il montre comment ces idées éclairent la compréhension de ses réactions lorsqu'il travaille avec ces personnes qui en ont déshumanisé d'autres. Une position marquée de sollicitude authentique permet à la psychanalyse de doter le traumatisme d'un foyer relationnel dialogique.

Il lavoro dell'autore con I veterani di guerra che hanno partecipato a situazioni di orribile violenza, lo ha portato a riesaminare l'azione terapeutica e il ruolo dell'empatia. Una autentica sollecitudine, come la descrive Robert Stolorow in *World, Affectivity, Trauma*, diventa centrale per la creazione di uno spazio relazionale in cui sia possibile elaborare e integrare esperienze emortive traumatiche. L'autore sostiene che dobbiamo usare l'empatia come uno strumento per ritrovare un'umanità condivisa con i nostri pazienti. L'autore descrive inoltre alcune modalità in autentiche di Essere per la morte che possono svolgere funzioni difensive inconsce sia per i pazienti che per gli analisti quando si misurano con la propria finitezza. Egli dimostra come applica queste idee per comprendere le proprie reazioni nel lavoro con pazienti che hanno partecipato ad azioni

di disumanizzazione di altri. Un assetto centrato sulla sollecitudine autentica nei confronti dei pazienti può volgere la psicoanalisi verso la capacità di offrire al trauma uno spazio dialogico e relazionale.

Die Arbeit des Autors mit Kriegsveteranen, die an schrecklichen Gewalttaten teilgenommen haben, hat ihn zu einer Neu-Untersuchung des therapeutischen Handelns und der Rolle der Empathie veranlasst. Authentische Einsamkeit, wie sie Robert Stolorow in *World, Affectivity, Trauma* beschreibt, bekommt eine zentrale Bedeutung bei der Herstellung einer relationalen Heimat, in der traumatische emotionale Erfahrungen verarbeitet und integriert werden können. Der Autor spricht sich dafür aus, dass wir Empathie als ein Werkzeug benutzen müssen, das unsere Menschlichkeit, die wir mit unseren Patienten teilen, finden, deren Herzstück die Endlichkeit ist. Der Autor beschreibt außerdem einige Formen unauthentischen ‚dem-Tod-Entgegengehens', die als unbewusste Abwehrfunktionen beim Patienten und dem Therapeuten auftreten, wenn sie mit der Endlichkeit konfrontiert sind. Er zeigt auf, wie er diese Vorstellungen benutzt, um seine Reaktionen in der Arbeit mit Patienten zu verstehen, die an Handlungen teilgenommen haben, die Anderen ihre Menschlichkeit nahmen. Eine Haltung, die auf die authentische Sorge um unsere Patienten ausgerichtet ist, kann die Psychoanalyse darauf ausrichten, eine dialogische relationale Heimat für das Trauma zu werden.

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